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# The Complimentary Roles of Occupational Therapy and Psychological Measurement in Rehabilitation

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The social sciences were full of young idealism and social security programs were unknown when the first rehabilitation legislation for disabled civilians was enacted in 1920. So advanced were the social ideas inherent in these programs that during the early period of development, understandable emphasis was given to vocational preparation and placement. As our social growth has come apace, our rehabilitation concepts have shifted from the initial economic values to the present day social and individual values. The economic value of rehabilitation has not lessened, but rather it is no longer necessary to apologize for the intrinsic, inter-personal and personal values of a social program. With the advent of broad social security legislation in 1936, vocational rehabilitation could begin to explore the possibilities of maximum service to the handicapped. Not many years later, the acceptance by the general public of a philosophy of complete service culminated in the Civilian Rehabilitation Act of 1943.

Rehabilitation ideas now embrace much from the fields of medicine, sociology and psychology, and, as a consequence, the idea of a team service to the individual has penetrated into the earlier history of the hospitalized person. Rehabilitation has become concerned with the period immediately following the onset of physical handicap or disability because at this point, many of the attitudes toward self and attendant self-reactions[3:97] are given their initial direction. It is at this point that reaction-sensitivity and a generalized response pattern to various excitants in an illness situation or as a result of a handicap are initiated. Trauma or acute illness may also serve to activate an old personality defect or cause a patient to turn to once learned but inadequate and discarded modes or mechanisms of adjustment. Because of its psychotherapeutic contribution rehabilitation activity has entered the phase of hospitalization previously left exclusively to treatment. The present trend in medicine is to treat the patient as a whole[14] and to make it possible for him to live a successful and happy life. Such an approach or attack calls for as diverse a field

of technical assistance as the physician can possibly muster. It makes treatment a team proposition.

We are indebted to Barker, Wright and Gonick for an excellent statement of the psychological bases for a concerted approach: "Education, vocational training and work, by allowing the patient to progress toward the important goals, are effective in aiding his medical cure because they change the situation from one of conflict and frustration to a situation which provides some satisfaction".(1:146)

No longer is treatment prescribed for an isolated organ or member of the body or trait or quirk of the mind, but treatment is now prescribed for a bio-social individual(3:11) a person who is distinctly but inseparably an organic and social entity. The new approach is electric; it transcends vocational, psychological, medical and psychiatric fields(4:188). Reggio,(17:149) has developed ten factors for a sound rehabilitation program suggesting the various areas and departments of a modern hospital program:

Mental hygiene
Social service
Morale maintenance
Physical therapy
Occupational therapy
Recreation and entertainment
Education
Vocational counsel
Physical & vocational rehabilitation
The will to get well

Teamwork has become the pattern for many a hospital and sanatorium and a consideration of the patient's vocational needs are the concern of the doctor, occupational therapist, social worker, and rehabilitation counselor(18:297). Earlier rehabilitation planning calls for earlier vocational diagnosis and here the aptitude tester and vocational advisor can be of service in making suggestions to the remainder of the staff for the channeling of hospital activity(5:285) The rehabilitation counselor, trained to use psychometric data and to apply it discriminatively in the counseling situation is also well versed staff for the channeling of hospital activity(5:285). His position on the clinical team will enable him to evaluate the patient's aptitudes and to make recommendations to the physician who will initiate prevocational activity through his prescription to the occupational therapist.

At Moore General Hospital, an army tuberculosis center, a planning board made up of all phases of reconditioning was instrumental in setting up a successful clinical program: "In the initial stage, vocational counseling and guidance was the crux of the total program, being particularly valuable in the original orientation of the patient. The primary objective of this service was to contact the patient, to discuss and help solve his immediate social and economic problems. This type of initial contact served to establish the rapport necessary for further counseling. Considerable exploration was made by the counselor with the patient in the field of educational and vocational possibilities. Such exploration resulted in establishing vocational objectives. Educational reconditioning and occupational therapy were utilized to carry the patient toward his objective while the patient was still in the hospital"(11:176).

Early steps in the hospital program for the tuberculous in Cuba, calculated to reduce recurrence of the disease, are vocational. "At the beginning of treatment a study of the patient's vocational aptitudes will be made to prevent his morale from declining and to give him a living faith in his ability to complete the treatment"(12:317).

The occupational therapist will have the advantage of early and relatively extensive contact with the patient. It is here wherein she can aid the counselor and psychologist by imparting valuable information which has come to her in carrying out the formula of the medical program(9:213). She is able to appreciate the patient "as an individual, and she can study his pattern of individuality for the potentials of interest, motivation, and capacity"(4:188). This is consistent with the newer approach in rehabilitation which places stress on the individual's interests and emotional life, as well as his capacity for learning(4:xx).

Broad occupational therapy objectives characterize the unusual implementation of the occupational therapist, who by temperament and training is prepared for her mission of carrying out the purposes of diagnostic and therapeutic medicine, and who thereby contributes to a comprehensive rehabilitation program.

The objectives of occupational therapy as usually stated, are those of muscle kinetics, muscle tone, metric determinations and psychotherapy(13:17). To these I have added the all pervasive and general objective of rehabilitation. Each objective as it is being realized permits of

valuable source material for vocational orientation.

### *THE OBJECTIVES OF KINESIS*

The associative learning theory of personality as outlined by Guthrie[7:61] explains personality traits as habit systems which grow out of simpler acts and movements. This theory emphasizes the importance of early experiences in adjustment and places work history at the top of the list of important data which will reveal stable habit patterns and hence may act as a background for behavior predictions.

In carrying out the physician's prescription for the therapy of exercise and use in the development of muscle strength and function, the therapist will have unlimited opportunity to elicit elements of work history and experience. As patterns of skills unfold, she will be able to build a valid and reliable case history.

The therapist will be able to communicate to the physician and rehabilitation counselor the important observations leading to disability evaluation. These observations will in turn form the basis for early talks toward appropriate vocational objectives in line with orthopedic impairments and functional loss.

### *THE OBJECTIVE OF TONE*

While the process of restoration to normalcy in physical and organic function goes on, the occupational therapist is able to make useful observations, not only on such fundamental correlates as psychomotor co-ordination, precision, and speed, but also on the many isolated factors in aptitude analysis[6:280]. Prominent variables for attention are perceptual speed, associative memory, general reasoning, verbal and numerical facility, spatial relations, visualization, mechanical experience, length estimation, visual memory, judgment, carefulness and mental set. While it is the aim of psychology to perfect instruments wherewith to isolate, identify and quantify these attributes, these same instruments tend to "amputate" the function from the individual's flow of life process with a corresponding disturbance of motivation and the introduction of new variables which do not have the same import in a dynamic situation. One of the limitations of modern psychometry is the necessity for relating behavior samples to a population norm. In order to bring about comparisons, it is first necessary to render each sample static. It is as if a motion picture film were to be rated by comparing each frame with a known standard (the static study). As valuable as this would be, an important criterion would also be served by gaining the effect of each frame as it contributes to the continuity of the picture as the film is run through the projector (the dynamic study).

### *THE OBJECTIVE OF MEASUREMENT*

Working closely as she does with the sensory mechanisms and media, the therapist is able to do initial screening observations (selecting the obvious subjects of malfunction for further study) on sensory performance.

Rough, but clinically important observations, are possible in the therapist's workshop. Hints as to visual acuity, color sensitivity and depth perception, hearing acuity, tactual sensitivity, balance and postural control are among the many cues possible.

The occupational therapist may contribute to psychological measurement in fields which are relatively unsupported by clinical studies. There is much to be contributed by a study of individuals in the industrial psychology problem areas of "work indices, the problems of fatigue, the necessity for extraverting activities"[4:191].

Physical capacity appraisal received considerable impetus during the recent war through the work of the War Manpower Commission and the Permanente Foundation[20:v]. Physical capacity analysis is now standard procedure in the placement services of public employment agencies, rehabilitation agencies and many private industries[15:162].

The occupational therapist is equipped to conduct measurements in work tolerance under the guidance of the physicians so that they may be incorporated in planning toward work objectives. Modern industrial psychology stresses efficiency and fatigue factors. An alert and modern rehabilitation team will furnish an adequate appraisal in this area. A typical forecast by Davis[4:192] is appropriate: "The indivdualization of the worker and work project for the purpose of more evenly matching the man and the job will be more adequately perfected".

Part of the effectiveness of a psychometric program is gained by the efficient and appropriate choice of psychological tests and their effective application[10:324]. The contributions of the occupational therapist are time saving in this

regard. The need for large exploratory test batteries is often minimized by her observations. She is able to speed up the work of the psychologist by working on patient attitudes and preparing the "field" in advance. As evidenced by experience of the author in tuberculosis sanatoria such procedures eliminate lengthy preliminary interviews calculated to establish rapport. Testing results are secured more quickly, are more reliable (fewer flippant or bizzare answer patterns) and there is ready evidence of friendliness and cooperation throughout the institution.

## *THE OBJECTIVE OF PSYCHIATRY*

The latest rehabilitation concepts strongly feature adjustive characteristics in all human relationships. Much has been written concerning the relative importance of intelligence and personality in job adjustment. Satisfactory and permanent placements are known to result when a person can completely meet the requirements of the knowledge and skills demanded by the job and at the same time adjust to the individuals with whom he is by necessity thrown into contact.

The effectiveness of occupational therapy in gaining the interest and attention of a patient in order to orient him toward goals of recovery and rehabilitation are evident in all types of hospitals, general, mental and tuberculosis. Under psychiatric prescription the occupationl therapist is able to capture motivating forces and turn them to the altering of personality patterns[19:327]. Concurrently, she will have reached a depth of understanding concerning the patient that will not be approached by the physician nor by the rehabilitation counselor because of the circumstances of shorter contact.

Although the list is by no means complete, clues to adjustment are obtainable in the following patterns of traits or their antitheses:

| | |
|---|---|
| Accessibility | Co-operativeness |
| Alertness | Interest |
| Assurance | Relaxation |
| Attentiveness | Reliance |
| Calmness | Responsiveness |
| Clearness | Sociability[21:98] |

Some common adjustive mechanisms and associated personality characteristics may be evidenced by overt behavior in many areas. A few examples of these areas follow:

Hostility: verbal attack, rigid negative attitudes

Aggression: attack, anger

Obsessive-compulsive behavior: repetitive, ritualistic, symbolic activity

Narcissism: bids for sympathy, selfishness, disregard for rights of others

Dependence: devices for evading responsibility

Masculinity-femininity indentification: aestheticism, activity preference

Regressive features: crying, temper tantrums, pouting

Psychopathic disdain: disregard for common values or social mores[5:285]

Psychological measurement, ever cognizant of the need for the statistical validation of behavioral observations, is presently seeking its verification through the longitudinal analysis or case study, rather than exclusively through a comparison of isolated reactive data with statistical norms. This approach is perhaps more clinical than psychometric, containing as it does, elements of pragmatism (proof through work), yet psychologists are asking that more attention be paid a subject's raw behavior in actual testing situations rather than relying wholly on numerical results[8:317]. The latter idea follows the projective hypothesis "wherein every reaction of the subject is a reflection of his private world and an index to his personal make-up"[16:10]. These concepts leave psychological study of interpersonal relationships free to explore individual behavior dynamics, which, in turn, will permit the full clinical utilization of the significant contributions of the entire rehabilitation team.

## *THE OBJECTIVE OF REHABILITATION*

The psychologist and rehabilitation counselor are dependent upon the occupational therapist not only for the direct assistance offered by observational data but for a number of general evaluations which contribute to an understanding of the individual, the whole person, and which are important factors in the rehabilitation prognosis. Initiative, creativeness, originality persistence, spontaneity, leadership, security needs and the like are appraisals which the occupational therapist can make toward the nature of the clinical setting. She will, by her oppor-

tunity to more completely understand the patient, be able to alert the clinical team as to nature of approach, direction of counsel and adequacy of plan. In her workshop are the problem situations which yield tell-tale evidence, in miniature, of habitual reaction patterns. Watching a patient take apart a chair to reglue it, time a soldering operation, guide a chisel across a knotty piece of wood in a turning lathe or struggle with a chattering piece of wood in a jig-saw, can yield information most pertinent to the final evaluation of the patient's skills and emotional control. There can be no question of the efficaciousness of planned teamwork in the rehabilitation of the individual. Handicapped workers have been shown to be better producers (24%), subject to fewer accidents (56%), and to have better job continuity (83%)[13].

The occupational therapist is an important unit in the modern rehabilitation structure. She will make possible an early unification of the medical, psychological and vocational aspects of hospital service. "Surely there is no one in the modern hospital personnel quite as well fitted to seek out latent skills, to rekindle dormant desires and quietly, day by day, to lead a sick body or mind into new fields of interest—frequently into new, exciting, and altogether satisfying careers of usefulness"[2:341].

## *SUMMARY*


Modern concepts of treating the whole person are bringing vocational programs into the earlier phases of hospital treatment.

Patients are oriented toward a carefully chosen vocational objective as part of the therapeutic plan.

Physician, occupational therapist, and vocational psychologist are mutually concerned with the proper psycho-physical and psycho-physiological evaluation of the patient.

The objectives of occupational therapy: kinesis, tone, measurement, psychiatry and rehabilitation, provide the framework for an understanding of the patient which is the firmest kind of foundation for psychological measurement and evaluation.


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# A Rehabilitation Program for The Tuberculous Through Occupational Therapy*

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Medicine today stresses the treatment of the "whole man", realizing the importance of the patient's extra-medical needs. This recognition has affected the role of the occupational therapist, particularly in the tuberculosis hospital. No longer is she also the librarian, the recreational worker, the educational instructor and to some extent the social worker and the vocational advisor. Professional workers in these fields have been added to hospital staffs, in order that these needs may be more adequately covered. Many therapists, trained to consider treatment with rehabilitation problems in mind and trying to fill as many of the obvious needs of the patient as possible, had used these activity outlets as treatment media. However, relieved of these phases of patient service, the therapist finds herself once again largely dependent upon the use of crafts as treatment media.

In re-evaluating the place of crafts in occupational therapy, two facts become apparent. First, there is opportunity and need for closer working co-operation with the medical staff in using crafts, not as hobby work, but as actual medical treatment. Second, carefully chosen and analyzed crafts can be of the utmost value to those directly concerned with the vocational rehabilitation of the patient. It is with these two thoughts in mind that the occupational therapy program has been developed at the Rutland Heights Veteran's Administration Hospital.

Occupational therapy is not new at this hospital. It has been an active service for many years, growing and developing along the above-mentioned trend. During the recent years following World War II, the department doubled in size and changed from a separate service to an integrated section of the Physical Medicine Rehabilitation Serivce. It is this recent period of development which will be described.

## *MEDICAL REHABILITATION AND REHABILITATION BOARD*

The separate service of Medical Rehabilitation, (later changed to Physical Medicine Rehabilitation Service), was established in May, 1946 by VA Central Office Circular[1] in all VA Hospitals. Responsible to Chief of Professional Services, this service is under the immediate direction of a physician-in-charge, the physiatrist. It consists of the department of occupational therapy, physical therapy, educational therapy, manual arts therapy, and, in other than tuberculosis hospitals, corrective therapy.

One of the more important benefits of this integrated program is that it provides the necessary close working relationship between the therapist and the physiatrist, who has had training in the direction of occupational therapy.

Since all activity is on a prescription basis occupational therapy is given to a patient because the physician intends to use it as another aid in attaining a medical purpose. Conversely, no treatment is given a patient unless approved by the patient's physician and the physiatrist.

Another recent development of direct interest to the therapist is the Physical Medicine Rehabilitation Board, which was established in December, 1946[2]. This Board was created for the purpose of further co-ordinating the various services concerned with the patient's complete rehabilitation. The physiatrist presides as

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chairman, with the executive assistant acting as secretary. A physician designated by the Chief of Professional Services serves as medical consultant. Other members of the Board include the patient's ward physician, the vocational adviser, the social worker, the training specialist from the local area, and the chiefs of the various sections of Physical Medicine Rehabilitation Service.

Patients, who, through screening by the physiatrist, are found to have a rehabilitation problem, are referred to the vocational adviser for testing, and then presented to the Board.

At the Board meeting, a complete picture is given of the patient's physical, social and vocational problems. Vocational objectives, arrived at through testing and guidance, are proposed by the vocational adviser, with detailed explanation of the physical activity involved. If the objectives are medically approved, an immediate hospital program is planned, correlating the activities available in occupational therapy, educational therapy, physical therapy and manual arts therapy. A date is set to evaluate the patient's progress in this hospital program and to review any changes or progress which has been made regarding his post-hospital plans. Through the Board, the vocational aspect of the crafts used in occupational therapy can be individually planned and the result evaluated.

Thus, the framework is set up for the accomplishment of both goals of the occupational therapist as previously mentioned: working closely with the doctors for medical progress, and integrating the crafts used with vocational plans.

## *THE OBJECTIVES OF PHYSICAL MEDICINE AS INTERPRETED BY OCCUPATIONAL THERAPY*

The objectives of the Physical Medicine Rehabilitation Service, as defined by Circular 121[1], are "to prevent the deconditioning phenomena that develop with bedrest, to improve morale and, by a program of planned and purposeful activity, to motivate the patient to recovery and productivity."

In occupational therapy for the tuberculous patient, these objectives are interpreted briefly as follows: to help the patient follow bedrest treatment, later to improve his work tolerance, while at the same time providing pre-vocational exploration, and finally, in particular cases, to aid physical therapy in maintaining and improving shoulder joint functions following chest surgery.

To avoid misunderstanding and confusion, the terms *tonic, metric and kinetic*[3] have been adopted to denote types of treatment used in occupational therapy replacing the miscellaneous terms formerly used, such as diversion, work tolerance, recreation, etc.

## *TONIC OCCUPATIONAL THERAPY*

Tonic occupational therapy is prescribed for strict bedrest patients (1) to help the patient to accept the difficult strict bedrest treatment, and (2) to prevent or relieve mental boredom which accompanies such treatment. Both aims are accomplished by developing the patient's interest in the creation of handmade articles. There is no specific working time limit in this type of treatment; rather, the control comes from the strict limitations of the projects used. To comply with bedrest regime all activity is limited to the movement of the upper extremeties from the forearms down. The patient works in a reclining position, with his elbows stabilized by resting them on the bed. Only projects which have been analyzed by the therapists' own trial, and found to be relaxing in this position and approved by the physiatrist are used in tonic occupational therapy.

*Tonic Work*

Treatment is evaluated by the extent to which it has aided the patient in accepting and adjusting to bedrest. It is interesting to note that the same project may have entirely different physi-

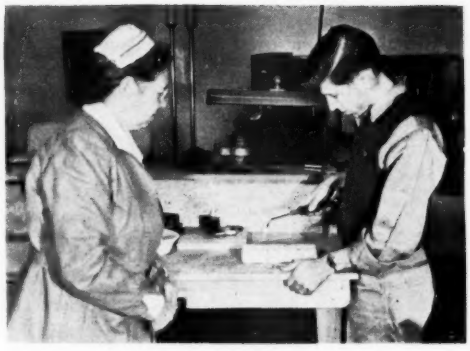
cal effects on different patients. Previous type of work done by the patient, degree of interest aroused, familiarity of projects and the personality of the patient are all controlling factors. It is therefore impossible to have any strict list of projects to use. In fact, variety is definitely preferable, providing the previously mentioned limitations are followed as the criteria for suitability. It is necessary for the therapist who is actually working with the patient to observe the result of the activity and to guide him accordingly. However, in general, projects which have been found suitable include light textile crafts and miscellaneous minor crafts.

Since tonic treatment is often the patient's introduction to OT, initial approach is extremely important. He is visited soon after he is transferred from the admission ward to a treatment ward. The "initial approach" may require a series of visits, depending upon his reception of the therapist. It is not considered complete until rapport has been established through common interests or experiences, the entire occupational therapy program has been explained, interest has been aroused in at least one activity and the patient is ready to start treatment as soon as his physician approves.

Inasmuch as the value of tonic therapy, like bedrest treatment itself depends upon the patient's co-operation, he must understand and appreciate the necessity for activity limitation and the gradation of projects. Therefore, tonic therapy is presented as a tool for him to use to aid his medical treatment. A feeling that he is actively participating in his own treatment often gives meaning and importance to projects which otherwise would not interest him.

## *METRIC OCCUPATIONAL THERAPY*

When the patient has improved to the extent of semi-ambulatory privileges, the physician changes the occupational therapy prescription from tonic to metric, and the latter is continued through the ambulatory period until his discharge from the hospital. Metric treatment is prescribed to improve work tolerance by the gradual increase of measured activity. In contra-distinction to tonic treatment, it is timed and graded. Time is individually increased by the physician and projects are graded accordingly by the therapist through craft analysis. Metric occupational therapy serves as a "therapeutic test" for the physician by the reaction of the patient and his disease to controlled activity. Consequently, the regularity of treatment is essential.



*Metric Work*

Metric treatment is sometimes substituted for graded walking exercises on the ambulatory ward. The physician may feel that a certain patient should not undergo walking for some medical reason, such as the fact that he is in the older age group or has a locomotor disability. At the same time, the physician needs an "exercise test" over a period of time to determine the activity of the tuberculous lesion. Whether or not this patient can be discharged with medical approval is often determined by his exercise test in metric occupational therapy.

Metric activity begins as bedside work, with such activities as fly-tying, leatherwork, chip-carving, rug hooking, stenciling, copper foil work and weaving on bedside looms available to the semi-ambulatory patient. Ambulatory shop work includes jewelry, ceramics, floor-loom weaving, photography and machine stitching.

It is during this phase of treatment that craft work assumes importance to those who are working on the vocational rehabilitation problems of the patient. When the patient has reached the semi-ambulatory stage, the necessity for presenting him to the Physical Medicine Rehabilitation Board is considered. If, through screening, it is found that he presents a rehabilitation problem, he is referred to the vocational advisor for interview and testing, and then his case is presented to the Board. With his tentative vocational objective in mind, projects in occupational therapy are carefully chosen which test or develop the specific skills involved in that objective. Evaluated progress is reported

to the Board on review of the case. Thus, metric occupational therapy serves as a practical try-out for both the patient himself and the Physical Medicine Rehabilitation Board.

### *KINETIC OCCUPATIONAL THERAPY*

By kinetic occupational therapy, we mean specific activity to restore or improve joint motion, muscular strength and muscular control[4]. Thus, for the tuberculous patient, it finds its chief benefit in treatment of the patient who has had to undergo thoracic surgery for control of tuberculous lesions or their complications. It is usually prescribed by the physician as a supplement and a follow-up to physical therapy.

For instance, prior to surgery, patients are briefed by the physical therapist in bed posture and postural movements which are to be continued during and following surgery. This is to prevent deformity and loss of joint motion, to develop conscious muscular control, awareness of good body alignment and maximum range of motion of the affected shoulder[5]. Since the patient is kept on strict bedrest for a period of usually four months following the last surgical intervention, no kinetic occupational therapy is prescribed although the patient remains on a physical therapy program.

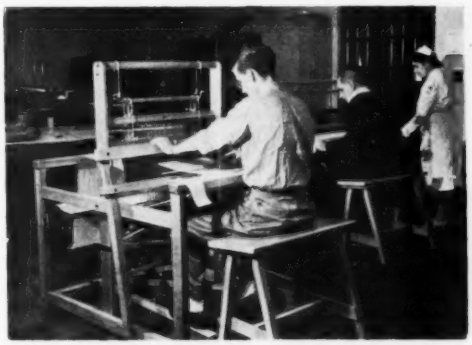
However, as soon as active motion is indicated, kinetic treatment is prescribed to supplement physical therapy. The activities used for this type of treatment must involve a variety of shoulder motions, must be adaptable, and, of course, must be made interesting to the patient. Since results can be evaluated more satisfactorily with standard projects, frame weaving on the treatment ward followed by floor loom weaving in the shop are most frequently used for this treatment. Although many of the patients regain full shoulder motion and can assume good posture following physical therapy treatment, it has been noted that they often revert to the "typical thoraco-plasty" posture when their attention is focused on any particular activity. Therefore, good working posture is particularly stressed, so that the gain made in physical therapy will not be lost.

Kinetic treatment is individually supervised by the therapist, so that the patient learns to work while maintaining good body alignment, at the same time improving muscular strength. Records of joint measurements are kept by the therapist and reviewed at regular intervals by the physiatrist. Metric therapy is often combined with kinetic to attain the dual aims of functional work and improvement of work tolerance.

### *TONIC-EXPLORATORY OCCUPATIONAL THERAPY*

One group of patients in a tuberculosis hospital presents a different problem from the medical rehabilitation point of view. This is the older arge group who have had their disease for a long period of time. They have an occasional positive sputum and are not expected to reach the stage of "arrest". However, eventually they will be discharged after maximum hospital benefit has been attained.

Their vocational problem is also different. The chance of their ever returning to the em-



*Metric and Kinetic Work Patient*

ployment market is dubious. The problem is rather one of supplementing their usually meager incomes. They are not eligible for the training provisions of the rehabilitation legislature affected after World War II. And, although they are eligible for rehabilitation benefits available to any disabled person, they must meet certain state medical standards of feasibility[5].

For these patients, we have had to provide a different type of occupational therapy, which we call tonic-exploratory. The aims of this therapy are (1) the promotion of adjustment to hospitalization and (2) the exploration and development of skills which may be of remunerative value after the patient is discharged from the hospital.

Because of the long standing nature of the disease, the strict limitations of tonic treatment

are not considered necessary. Rather, stress is put in encouraging the patients to explore any activities which might be continued at home, such as weaving, fly-tying, art work, leatherwork, wood-carving. All skills or limitations are noted, as well as the patient's interest in each activity. Whenever any talent or deep interest is discovered, he is encouraged to continue extensively with that particular activity. Volunteer aid is employed for advanced work. Many of the patients have found very satisfactory activity outlets, which, carried on now at the hospital, can be continued equally successfully at home after discharge. He can work at his own speed, has no output demands, and yet has an activity which will supplement his pension.

Thus the occupational therapy program is made up of the four types of treatment: tonic, metric, kinetic and tonic-exploratory.

## *VOLUNTEER PROGRAM*

An adjunct to the occupational therapy program which deserves much credit and recognition in promoting better patient service, is the volunteer program. This program, which has been active in this hospital for the past two years at least, has proved to be most valuable in permitting more patient coverage, longer instruction periods and providing advanced training to patients showing ability in a specific craft.

Because all activity in a tuberculosis hospital is of medical importance, there can be no sharp line of distinction drawn between therapeutic and diversional activity. Consequently, it is necessary for all volunteer work to be closely co-ordinated with occupational therapy. In this hospital, volunteers work directly with therapists and are responsible to them for the medical phase of their work. Each volunteer is instructed on general working procedure with the patients. Emphasis is put on good bed posture, elimination of chest motion as much as possible with strict bed patients, adequate lighting, and signs of fatigue.

The craft training of a therapist is diverse rather than intensive. A volunteer, experienced in one craft, can be of much help to the patient whose interest in a craft is more than casual. This is particularly true of the tonic-exploratory group. In several cases, projects originally given for general therapeutic purposes, have become of definite interest to the patient, and, developed with the aid of the volunteer, have resulted in pre-vocational or remunerative activities for the discharged patient.

## *CASE STUDIES*

Following are two case histories which illustrate the attempt to provide occupational therapy which is medically beneficial and vocationally pratical.

Patient R. M. was a window display man and wished to return to that work after discharge from the hospital. However, when his case was discussed at the Physical Medicine Rehabilitation Board, that objective was not approved for the following reasons: The patient had far advanced disease, which was protected only by pneumoperitoneum, and sensory disturbance in both hands caused by service-incurred frost-bite. The patient's secondary interest, photography, was considered medically feasible. Occupational therapy followed up the Rehabilitation Board recommendation by encouraging and giving the patient instruction in photography. Although his progress was good, the patient himself was not convinced that he could not return to his former work. He was therefore referred to an Arts and Skills volunteer artist who worked with him on a miniature window display. This gave the patient concrete evidence of the extent and the effect of his sensory disturbance and he then accepted the Board's decision. The remainder of his hospitalization was spent in developing his photographic ability. Upon discharge, he entered a photographic program.

Patient C. A. was a manager of a chain grocery store prior to hospitalization. This patient himself reached the conclusion that the long hours, heavy responsibilities and the occasional manual labor required for a small business of this kind made it inadvisable for him to return. While a bed patient, he showed interest in design, and enjoyed working out jewelry designs. Later he did excellent work in textile painting, showing unusual ability. When he reached the ambulatory ward, his activity time in occupational therapy was concentrated in jewelry. During vocational advisement his ability in jewelry was borne out through testing, and the objective of jewelry maker was proposed and approved by the Rehabilitation Board. The cooperation of a local Volunteer Services Chair-

man with the vocational advisor resulted in an excellent training program with an Arts and Skills Guild. Occupational therapy for this patient has been an example of pre-vocational work try-out, in which shop work substantiated vocational testing, and the patient's interest in jewelry was tested and developed.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# Some Factors of Importance to the Occupational Therapist in Psychosomatic Medicine


LUCY G. MORSE, O.T.R.


Vivid experiences help to start and often crystallize one's thinking. I shall always remember one of my first asthma cases. The rather violent contrasts between illness to the point of being in an oxygen tent and, within a few hours, comparative health, were impressive enough. His ability to stand at a workbench and with considerable interest and attention, print an etching that had been cut earlier while he was in bed, was pleasing to patient and therapist not only for the accomplishment of a rather well done finished product but for the apparent physical improvement in that, when occupied, this patient seemed to have much less need of adrenalin. One doctor with a shrug said, "it was all mental," inferring that the patient could control the number of attacks. Another doctor's remark was, "wouldn't you be scared to death if you couldn't catch your breath." His own doctor rather casually said, "now you see how much better you are when you are in occupational therapy. The thing for you to do, is to go home and get busy in your garden or get some light work outdoors if possible." It was evident this did not particularly satisfy the patient. He returned home to another state and there was left in my mind a great dissatisfaction about what had really been done.

In contrast, another patient was admitted to the psychiatric ward with a ten year story of attacks of neusea and headache. After each of her admissions to another hospital, the symptoms subsided and the doctors could find no organic basis for the attacks. She was finally sent to us with a diagnosis of psychoneurosis. Upon careful examination, she was found to have an inoperable brain tumor.

The development of psychosomatic medicine has seemed to fill a gap in the processes used in the total rehabilitation of patients and yet it is not always the whole answer. During the time between the treatment of the first case and now, there have been and still are, swings of interest about the seemingly less tangible "mind" difficulties of patients. It is gratifying to read the studies of men such as Dr. Cobb, who are actively trying to define the borderlands of psychiatry. The study of the body and mind relationships is helpful to one who serves as part of the rehabilitation team and must see the whole individual during the course of an abnormal to a normal life situation. It has always been easiest to treat the conditions with a known physiological basis especially when such patients accept the suggestions made by the physician or therapist. The less well known physiological conditions and the mental attitudes of people toward illness have not been as easy to analyze.

Weiss and English point out that between the psychoses and the truly physical disorders, approximately one third of the patients do not have a definite bodily disease to account for illness and are therefore the functional problems in medicine. Another third have symptoms that are in part dependent on emotional factors. In other words organic disease does exist but the psychic factor is able to do more harm than in the first group. A final third of the disorders are generally considered physical, such as asthma, ulcerative colitis, etc. Dr. Deutsch in showing his more analytical methods offers wide possibilities for greater understanding particularly for the technician whose main means

of success lies in the proper use of interpersonal relationships.

The goal of the occupational therapist is usually to achieve certain specific mental or physical results desired by the physician. To start she must begin with the daily life of the patient as does psychosomatic medicine though the two goals may be different. Depending on the emphasis of treatment, she must adapt the activities either to his organic or psychic needs or both. They are merely a means to an end and her ability to understand how or why the patient does certain things in relation to either the activity or to her, allows not only for better but quicker results. The objective interest of the therapist is not always understood largely because of the subjectivity of the patient and other workers around the projects being done. However the fact remains, this therapy can be of more help to the doctor and patient if an objective point of view is demonstrated by its goals.

The part Freud and Cannon have played in paving the way for the present research in the field of psychosomatic medicine is clear. For a long time medical men did not understand psychiatry and as Alexander says, "refused to admit symptoms that had no organic basis." Today the concept of psychosomatic medicine has been defined as "the systematized knowledge of how to study bodily processes which are fused and amalgamated with emotional processes of the past and the present." Behind this lies the need of an understanding of the broad patterns of human motivation and the common causes and backgrounds of emotional disturbance as well as the relationship between this and illness. In assisting the physician in applying the knowledge as therapy, one needs to know something of the qualities and value of the worker-patient relationship.

In the "dynamic genetic" schools of psychology, one sees an approach beginning with life experiences in infancy particularly during the first five years. There are certain primitive biological needs common to all individuals. Reactions to gratifications and frustrations reflect the experiences learned in this period. Cannon has shown us something of the correlation between certain types of bodily function and personality and in psychosomatic medicine, we are beginning to know more of how the human being may use the body and its functions to express emotions.

Thus, the ability of the ego, our security mechanism, to face reality and solve conflicts varies with each individual. One is able to arrive at solutions only when the ego can make peace both inside and outside the body. It is important to try to understand the balance between instinctual and body drives (within) and/or physiological and inhibitory processes (without). The unconscious method chosen by the patient is the solution for a conflict which does not cause him anxiety. If this solution is removed or changed without the proper substitution or insight therapy, it is possible to make the individual worse. The reasons behind the choice of various solutions need to be understood in order to offer constructive therapy.

It is necessary to observe the degree of reaction and the age and period of it. Deutsch calls this "associative anamnesis" and shows that the phase in an interview when a patient presents his ideas brings out how the conflicts are motivating him and how well developed they are. Much of the material one reads today points out that one no longer comes to a diagnosis of neurosis by exclusion. Positive information must be obtained showing actual conflict either with environment or from within, and the patient's attempt at a solution. Some diseases have important psychogenic aspects. *If an organic disorder appears at a time of emotional impasse, the coincidence may bring an amalgamation of the organic and emotional processes and again it may not.* It is the latter that brings the patient to us.

There have been many studies of specific diagnoses to demonstrate this concept. For example the normal existence for a cardiac child is limited by the treatment requirements of the disease, one of which is bedrest. The child may quickly learn certain advantages to illness and use his symptoms as a means to an end. He may adopt a fearful, clinging vine type of behavior as reaction to an over-solicitous parent. Inferior feelings are frequent. The basis of this feeling, Dr. Deutsch states is usually in the realm of muscular activity where the child is unable to compete with other children. It is hard for some to find substitute gratifications for muscular activity and as a result anxieties may develop which manifest themselves in a number of ways. The occupational therapist must recognize the individual problems objectively and assist the child and often the parent in handling them. The medium of occupation

can be an important means of finding an acceptable substitution and often a solution.

It has seemed to me that the long convalescence of cardiac and other diseases such as tuberculosis and arthritis should not be a period for the development of abnormal symptoms in good modern medical care. Unfortunately, some cases are not referred early enough and some are affected by the lack of facilities for adequate care, reasons which allow for the development of problems. Ideally good care requires a team of workers rather than one individual and a knowledge of the peculiar needs of the patient among the members of the team as well as where or from whom the patient can obtain the most help at a given time. In actual practice however, it is not usual to find a complete and co-ordinated team. More often two members may work together such as doctor-social worker, social worker-occupational therapist, doctor-occupational therapist and so on. Due to lack of time for many individual conferences, the central medical record of the patient becomes the only regular source for material of all the different workers on the case. Again these are often not up to date and sometimes do not include all the records. The art of making the most of the many casual or personal contacts one may have with a patient is important too but more will be said about this later.

For those diagnoses then, where convalescence takes a long time and the physical comfort of the patient is a predominant factor as with arthritis, there is opportunity for the development of physical or mental problems. These in the main can be treated successfully on a relatively superficial level as long as the problem is not allowed to become too severe. They can be taken care of by almost anyone from an intelligent parent to a professional worker. However, a knowledge of psychosomatic medicine is of great assistance in order that a better interpretation can be made of all existing information on a patient and from which help may be requested when necessary. Deutsch, Coleman and Schless all deal with underlying needs of individuals during the course of such diseases as cardiac disease, tuberculosis, and arthritis respectively and it is helpful to follow the observations of such writers.

A more thorough study carried on by Alexander and French on asthma indicates better the concept of the psychosomatic causes of disease. They state asthma is a symptom not a disease, and go on to describe the usual concept of the internal and external physical causes as well as the pathological changes. They have carefully studied the emotional factors and while difficult to prove, have made some rather sound observations. Other studies have pointed out similar findings. For example Weiss compares an attack to the protest of a newborn baby against separation from its mother. Dunbar has brought out disturbances in sexuality as shown in the predominance of anal and oral sadistic material. These patients have compulsive characters and develop few protective rituals for example. Alexander and French demonstrate the traumatic character of precipitating situations. Sometime just the threat of separation from a mother presents too acute a problem for solution; the ego is not ready for it. The personality structure of the individual shows a deep seated insecurity and a need of parental love and protection. In their defense they seem "to bridge the stage of infantile helplessness and psychosexual maturity in one leap," taking an alternate role between parent and child. Other precipitating factors may be sudden intense emotion, sexual conflicts, indentification with dyspnoeic attacks of others or secondary utilization of attacks.

It is not known which is the primary factor, the conflict or the attack. But it is significant to note the relationship between asthma and "suppressed crying". Dream studies have brought out intrauterine phantasy material. Mothers of asthmatic children often belong to the rejecting mother type. Knowing this and something of the independence of the individual, one can understand this dream material as being an unconcious attempt at solving the desire for shelter (that of the womb) in the adult. In the child, however, breathing is the first step toward biological independence. In the period of real dependence, the child's need for shelter or protection is such that when it is frustrated, his physical reaction may relate to his breathing activities and take the form of "suppressed crying" or the early asthma attacks of childhood. The case material showed that the threshold for sensitiveness seems to be dependent on the emotional state, for once the emotional conflict is overcome, the individual seems to be more resistant to allergies.

How can the occupational therapist and other workers help in psychosomatic medicine? The

first service seems to fall to the realm of the social worker in augmenting the history. In the opinion of Dr. Deutsch she cannot ask too much about the past. There are certain topics that should be covered but the interviewer should allow the patient to express the thoughts that come into his mind in the order he wishes and without too much suggestion. It is good to mix bodily expression with emotional expression in order that there may be a shift in tensions. The questioning should go in the direction of what is being said. Repetition of key words or a nod of the head indicating interest is often enough. This is usually easier for the doctor than the worker because of the prestige of his position but the art of being alert to the clues which a patient gives regarding his birth, his feeding habits, and early experiences can be acquired and add important information to the physicians history.

It is not the goal of the occupational therapist usually to try to obtain this kind of information but fairly frequently over the neutral means of an activity a patient will talk more freely than upon direct questioning. It is just as necessary for this worker to be aware of significant material and to note the times and circumstances under which it is presented. The importance of never interpreting a symptom for a patient holds just as much for the occupational therapist as any other worker. In a sense the occupational therapist has a time advantage in that she usually sees her patient daily and hence over a period of time can observe or hear information that is helpful for medical evaluation.

Another value of the team of workers is the role-taking function of each. The patient may use the doctor in the father role, the therapist in the mother or sister role and so on. The study of inter-personal relationships is essential in psychosomatic medicine. It is obvious that one tries to understand the patient as much as possible but it is equally important to be well disciplined oneself.

The interviewing methods of Drs. Deutsch and Finesinger using a minimum of activity on the part of the interviewer are most instructive. The need for emphasis on the patient and his problems is always paramount but it is frequently the practice of the worker to be too active in her contacts. The ability to gain a maximum amount of information on a minimum of questioning and time is a good point to learn.

In interviewing one should make use of all kinds of things. The remark of a nurse as the worker approaches a patient on a ward may give a clue as to how many interviews have preceded hers and hence how tired her patient may be. It may give a lead on what the patient likes to do. The nurse may be projecting what she likes to do in trying to get the patient interested. The patient may have a *bad actor* reputation on the ward. His non-verbal behavior may show a good deal and so on. Interview situations differ; that between doctor and patient, social worker and client, occupational therapist and patient do not necessarily have the same goals. The common goal of each is the termination of the relationship; to try to reestablish the patient as an independent individual. Each may have many intermediate goals and these may change as new information is obtained. If these goals become too scattered or there is no goal, it is often an indcation that the patient is directing the situation in the way he wants, thus avoiding dangerous material. It may be that the interviewer does not know what to do next. When this last occurs it is best to come back to familiar points and work from there again. A doctor for example, has for his first goal, to find what is the trouble. The next is to make a diagnosis and then to treat the patient. He may have two or three plans ready to try. When one has no goals, it is at these times that one makes mistakes. A goal may be exhausted in five minutes and it may be worked for six weeks. Usually among the last goals may be the prevention of recurrence of symptoms by adequate insight therapy and finally the termination of treatment. So with the occupational therapist, if her goals for her patient are not well planned, her work becomes aimless and the word diversion which we resent so much, becomes well applied.

The goals of Dr. Deutsch are sound for a psychoanalysis and when working for such a doctor, the occupational therapist may assist by recording any accidental material she may obtain. As a technique for her own use, it does not seem to be practical as she has neither the training or the skill required. It is a help as background to know what the social worker and the doctor find out. In other words all this psychoanalytical material is a sound approach to the etiology of so many of the prob-

lems we handle that an understanding of it is of inestimable value to the occupational therapist.

Dr. Finesinger, by contrast, takes the patient where he finds him and works rapidly from there. As this is where the therapist must start it seems the more practical method for us to learn. The writing of records has been practiced for sometime. There is no doubt that this is a form of analysis of progress but usually it includes only what the worker wants to include. In the study of why a person says and does a thing, one must take into account to whom it is being said and if this has any bearing on what is said. The method of writing the interview word for word, including the interchange of both patient and worker is excellent. One can learn to develop certain skills by analyzing these records following interviews. It is granted that it is a method for a research program only. It is a fair recording as in any interpersonal relationship there are always two personalities affecting each other. In the past the entire attention has been on the patient and little if any has been given the methods of the worker, especially in occupational therapy. In going over a record such things as immaturity may be seen when the talk includes considerable nonsense. Too aggressive or too passive approaches show up. Sometimes one reads into the material, her own problems. Sometimes she has difficulty in letting go. Having a "hunch" about things or a "feeling" for it, is not always correct. One must test it out. The collection of one's experiences assists the worker to analyze herself a little and eventually to acquire skill in her own disciplines.

It is good to consider behavior of people as being reaction to stimuli. In the normal person these reactions tend to become modified. The patient, however, does not usually follow normal patterns. His reactions may be very personal, more subtle or not appropriate to the stimuli or in intensity. For example he may express a fear of high places and then tell of his hobby of climbing mountains. In hysteria there are a series of reactions which when put together help in the recognition of this diagnosis. The patient may bring out neurotic traits in telling of her youth. She is inaccurate in memory and uses her symptoms to change situations. She does not know the line between phantasy and reality and this along with certain physical signs give the diagnosis.

Patterns of behavior can be studied easily by the occupational therapist. The selection of an activity, the way it is done, talked about, used in relation with other patients or the therapist are all signifcant. If the patient responds to an approach and selects an activity himself, progress will be made. If the therapist superimposes her ideas on the patient, there will be no progress. An excellent illustration of the study of interpersonal relationships in occupational therapy has been given by Miss Peabody in her work with ulcerative colitis patients.

Finally on the subject of obtaining information, there is altogether too much indiscriminate use of reassurance in occupational therapy. Instead of being a method of helping in social relationships, it is a method of blocking. The only occasions for its use might be when a therapist is getting too close to *charged material* which the psychiatrist should handle. There may be times when this is the goal of therapy but otherwise in professional work more attention should be given to a careful use or avoidance of the means which one usually depends upon in social relationships.

The introduction which Dr. Finesinger gives to "insight therapy" illustrates a valuable quick method for therapy in the neurosis and in psychosomatic disorders. The principles of this technique have been indicated but in summary it is important to develop an effective physician-patient relationship. How this may be applied by occupational therapists and other workers has been shown as it is really the first step in any professional association with patients.

The principle of direction, that is, goal directed planning, gives a purpose to our relationships. In occupational therapy it may be the order of the physician to start with little direction in order to see what patterns the patient will assume and the effect of these on his current adjustment. Goals are necessary even here in order to select the variety of activities to be used to demonstrate what is wanted. In goal directed therapy a talkative patient may indicate what has been going on in his interview with the doctor. What the therapist learns is usually pretty superficial. But the patient is attempting to sound the worker out and it should always be remembered that the physician does the interpreting and never the therapist.

The prinicple of focusing or channeling on topics relevant to goals has not been touched upon in relation to occupational therapy. This,

except in such closely supervised examples as told by Miss Peabody, is not usually its function. However, through the recording of interviews, an excellent idea of methods and pitfalls can be learned. For example, it has not always been possible to distinguish what is *charged* material and what is not. In listening to some of the recordings, the slight hesitation of patients before answering gave me my clues better than almost anything else. I refer in this last to some victrola recordings which have been taken. It is necessary for therapists to be interested in patients but selective indication of interest is not necessarily an early goal for them. If and when directed by the physician, it may become a goal especially toward the end of a course of treatment. By this is meant those cases where there is a focusing of interest in activities that may be used following discharge.

Finally the principle of minimal activity on the part of the worker and maximal activity or initiative on the part of the patient has been well demonstrated by Drs. Deutsch and Finesinger. This should be given more study in occupational therapy. I do not feel the scale of low activity used in the recordings is practical except for the physician, largely because our goals are not solely to get the patient to talk, but as teaching material they are excellent.

Dr. Watkins has indcated that further research is needed in occupational therapy. It would seem that the subject of interviewing and interpersonal relationships might be a constructive place to begin. Certainly there is a wide field of study open to us here as little scientific attention has been given it in our profession.

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The Department of Child Study, Vassar College, announces the release of a film entitled "Pay Attention: Problems of Hard of Hearing Children," to be distributed by the New York University Film Library, 26 Washington Place, New York 3. The film (16 mm. black and white, sound, 3 reels, running time— 30 minutes) is available for sale at $110 and for rental at $6 per day. This is the sixth film in the Vassar Series, "Studies of Normal Personality Development," and consitutes part of a program of research and public information on problems of the hard of hearing, carried out with the help of a grant from the Estate of Lester N. Hofheimer, initiated under the direction of Dr. Mary Fisher Langmuir.

# The Scope of Music Therapy

ISABEL PICK ROBINAULT

*"Music reaches all the way from the little song within our hearts to the silent none-theless realistic 'music of the spheres' ".*[8]

This limitless boundary of music has been fascinating man ever since he first rocked to its rhythm in his tree home and answered the birds on the outer edges of the branches. Down through the centuries, man has adapted music to his prayer, his love song, his cattle cry, his heart's anguish, and his magic incantations; and music has revealed the many facets of her possibilities in rhythm, pitch and harmony. This interdevelopment has been grasped intuitively by the poets, and it is now the contribution of the scientific age to add experimental analysis to these heartfelt hypotheses. Those of us interested in the specific factor of music as therapy are no longer satisfied with poetic testimonials, such as the famed example of the wisdom of the poets in joining music with medicine in the character of Apollo "because the aim of medicine is only to tune up the harpman's body—and to make all parts harmonious"[17]. We now wish to know: what are the factors in man making him sensitive to this outer experiences and what are the elements in music — qualitative and quantitative — which exert this influence. When this is available, we shall then be able to discuss types and quantities of dosage; we shall be discussing music therapy, not just delving into parlor enthusiasms of the uninitiated who claim "Music just cannot help being therapeutic!"

The occupational therapist has every reason to be concerned with music as a tool, for it is an amazingly plastic one: a. There is music already on record for every age from childhood to the highest intellectual capacity. b. There is music for diverse moods (see ref. 15, also consult such sources as WQXR, WNYC, and Musak). c. There is music for social and creative dancing, for exercise, and for eurythmics[4]. d. Music may be used passively or actively[20A]. e. Finally, music can be obtained in forms adaptable to patients confined to bed, a single room, or completely ambulatory. Therefore there is a wealth of material, and it is the task of the therapist to select wisely and apply it intelligently. Therapists may claim that they do not have sufficient training or aptitude, or even time for music therapy. This may be true since ideally the job would be best handled by a trained musical aide, as suggested by Dr. Licht[10]; this aide would have a relationship to the O.T. similar to that existing between correlative exercise personnel and physical therapists. However few institutions have the finances or the convictions to employ such an aide, and although the occupational therapist may not be able to use all possibilities of music therapy, it would be wise for her to be acquainted with them and be able to select those adaptable to her program and to the potentialties of her volunteer staff (many of whom may have excellent musical training which would complement the therapist's guiding principles)[9, 13, 20E]. The occupational therapist who is interested in the possibilities of this medium will see that it can be adapted to the full scope of occupational therapy: preventative; diversional; functional; and prevocational.

## PREVENTATIVE OR DIVERSIONAL

As a Hospital Recreation Worker for the American Red Cross during World War II, I watched men leave their places at the work bench and go over to rewind the never-ceasing victrola; I watched them tie airplane wire on string instruments after the worn-out originals were beyond repair; I watched them toss coins for the one portable victrola that 18 wards had to share during the depression of overseas supplies in 1943; and finally, I watched them luxuriate in all possibilities of musical noise at a completely equipped general hospital. The demand for music in the hospital was constantly present and although our sources of supply were limited, the complete scope is well outlined by Special Service Music Division of the Veteran's Administration[20A,B]. This outline is as applicable to civilian hospitals as to the veteran's hospital since the type of music chosen to fulfill the categories will adapt it to the group or individual requiring music recreation:

I Music Recreation
- A. Individual instrument playing in band or orchestra.
- B. Glee club or choir
- C. Request program
- D. Band & orchestra concert

II Music Entertainment
- A. Community sings, with and without slides (see ref. 12, p. 56)
- B. Concerts and recitals
- C. Selected radio concerts (or recordings on public address system)
- D. Musical Quiz program

III Music Recreational Education
- A. Individual and group instruction
  1. vocal
  2. instrument
  3. creative
- B. Live Music Recital with comment
- C. Music appreciation groups

This outline did not mention "background" music but experience has shown that rhythmic gay music changing to soothing compositions have a definite patient response at meal time[4A]. Also music at intervals and of similar character to programs for industrial use makes a cheerful background for work in the occupational therapy shop.

## FUNCTIONAL

I To Assist in the Restoration of Articular and Muscular Function:

Music has increased the efficiency of those movements requiring expenditure of nervous and muscular energy[16]: muscular contraction has been increased (a) by sound made simultaneously with movement, (b) with the intensity of sound, (c) with increases in pitch, and (d) music may vary the steadiness of contraction. References[16 and 18], point out the additional fact that music may either lower the threshold of fatigue or alleviate it temporarily. These factors may be used by incorporating music as background for guided exercises[2] or by patient participation with an instrument chosen specifically for the motions involved in its execution[10]:

Example:

| Part of Body | Typs of Motion | Best Instrument |
|---|---|---|
| elbow | pronation-supination | guitar |

In as much as music of a rapid tempo, accentuated rhythm, and elevated volume has been found to have a stimulating effect[10] while that of slow tempo, reduced volume, and recognizable melody has been found to have a sedative effect, this may be applied to muscular relaxation. This has been incorporated into the therapy of cerebral palsy[2] in connection with hydrotherapy[4AO], and the goal of relaxation of speech and throat muscules may be reached in some cases through guided singing lessons [2, 16].

II To Improve the General Condition:

A musical educator[4] developed Eurythmics to train people to react physically to perception of musical rhythms since "musical sensations of a rhythmic nature call for muscular and nervous responses of the *whole* organism." Gesell[7] has found a definite development pattern of music response in children under five which may be used as a stepping stone for those who are in doubt about the grading of this type of therapy. On a purely physiological basis, the following over-all results have been found: Music may increase metabolism[16], accelerate or decrease the regularity of breathing, produce marked effect on the blood pressure, pulse, and blood volume[16, 4A], and influence the index of fatigue[4A].

III To Aid Mental Rehabilitation and Treatment of Mental Disorders[10]:

A. By Listening

1. To improve attention. Psychological basis for this is the hypothesis that music lowers the threshold for sensory stimulations of different moods[16] thereby lessening distraction and placing a reality factor before the patient.

2. To maintain interest. Music may be selected which takes cognizance of the patient's condition[16 14], intellect, and personality.

3. To influence mood. Music should not be too highly complex or emotional—it should be free from stress or strain[16] since it is one of the most potent conditioners of mood.

4. To produce sedation (see Relaxation under Functional Therapy, above). Relaxation in hydrotherapy, electrotherapy[20E], and accompanying massage[2] is aided by the proper selection of musical tonics and sedatives[16].

5. To release energy. The response of patients to planned musical programs has given much material for comparative evaluation. Paperte[14] tried an interesting experiment of subjecting persons with the mental disorders to diverse types of music and conversely, persons with different mental disorders to the same type of music and she obtained a collection of definite verbal and active responses. Others have

charted the flow of speech in hydotherapy by music[16, 4A, 20E], and still another investigator played records while patients wrote all the words and phrases that came to their minds at the time[6] and many provocative results were obtained.

B. By Participation

1. To bring about communal cooperation. In group singing, band or social dancing the individual must subjugate his interest to the group result and must cooperate toward it. Music must be selected with an eye to the ability of the group rather than toward virtuosity[4A].

2. To release energy. Playing a musical instrument requires physical as well as mental effort associated with a tangible reality. Playing, singing, or dancing also guide emotional energies into reality outlets.

3. To increase self-respect by accomplishment and success. Whether this is realized through the creation of sound or through development of an educated response to music, it is an added rung on the ladder of normal accomplishments. Care must be taken to guide this away from sheer exhibitionism or further justification on the patient's part for introversion or narcissism since Van de Wall is eminently correct when he points out that[19] "Only when music activity develops and strengthens normal behavior of patients can music be said to have a constructive function that justifies it being included in any hospital treatment program." That is why music therapy is not just letting a patient go haphazardly at a musical outlet; it must have purpose, organization, and control[19].

4. To increase personal happiness by giving opportunity for self-expression and initiative. Since music is composed of a variety of elements (pitch, intensity, timbre, duration, rhythm, melody, mode, and key) it is one of the least confining media of expression. Some mold its elements for mechanical stimulation, others for inherent spiritual values that they feel are contained therein, or for the aesthetic lift they receive, or most universally for the emotional rapport of their selection. "Success lies in presenting it in such a way that each individual finds that for which he is looking"[4A].

## PREVOCATIONAL

Music is an excellent hobby since it exists in such diverse forms in the communities to which patients will eventually return; it also can fit into any budget . . . therefore anyone truly wishing to develop and continue this hobby awakened in the hospital will have a minimum of resistance in the environment to which he will return.

The patient who will have to increase his coordination for the better execution of his vocation would do well to investigate the possibilities of music since it offers eye-mind-and muscle coordination which may be graded according to his needs and capabilities.

The patient who must face long or permanent hospitalization will find that music is one medium which can be transported in its entirety within the walls of a hospital and whether one is a bed patient, or completely ambulatory, there is some form of music or music appreciation which he can develop into an ever expanding personal gratification.

Finally should musical talent have been uncovered in the hospital or should a person have harbored a leaning toward a professional musical life, the hospital could offer ample chance for experimentation within the field, for testing out factors of endurance and social demands (by joining choirs, bands, or giving ward performances, etc.), and by checking and evaluating the person's disability in relation to his chosen interest.

The occupational therapist whose imagination has been fired by the pliable and varied scope of music as therapy will find that not only is she opening a new avenue of healing for her patient, but should she apply the measurements of the experimental method, she will be contributing to the all-too-meager literature upon the subject.

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# A Rhythm Band For Mental Patients

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This report covers one season, from September through June, of a rhythm band for mental patients orgniated in Rockland State Hospital. Although started as part of the recreation program, there were aspects of such great therapeutic value that this report will deal solely with these aspects, not forgetting the therapeutic value of recreation in its own right.

During the nine months to be reviewed, forty-seven different female patients participated in the band. Of this number, never less than fourteen or more than twenty-two ever participated at one time. This was due, primarily, to the lack of time and facilities necessary for covering the maximum number. Added to this, the band consistently worked toward a performance of each group of numbers studied, making it impossible to retain those of the group who were not capable of being included in a performance. Also, there was a fairly rapid turnover, some patients going to work, some going home, and those whose interest was not held beyond two or three rehearsals (Fig. 3).

Presentation of the goal, a performance of all numbers rehearsed, was deemed a necessary motivation for the better patients. However, for patients unable to reach a performance level this method proved detrimental. It was impossible for some of these people to improve rapidly enough, though many put forth a great amount of effort and derived much pleasure from playing. Of the total number (47), eleven patients (23.4%) were dropped for this reason (Fig. 3). Had the necessary time been available, this problem could have been solved by having two separate groups, one to be a "feeder" group for the performing group.

There was no effort made to teach the patients anything specific about music other than the most basic rules: keeping in rhythm with the accompaniment, playing and ceasing play when necessary, following the motions of the director, etc. This was based on the assumption that the benefit to the patient was of more importance than the music. It was necessary to keep things moving rapidly in order to avoid monotony and retain the interest of the patients at all times. This necessitated the fastest and easiest possible method of preparation for the completion of a number.

Time was not counted in the orthodox fashion. Each time a new instrument, or group of instruments played, the count would begin on *one* regardless of the musical value at the time of change (Fig. 1 & 2).

In all but the initial group of numbers the patients were encouraged to choose their own music, also to offer suggestions for improvement of the arrangements made by the instructor, many of which were accepted. Usually several

rhythmic or instrumental effects were worked out in each number, played, then openly discussed, the patients deciding which to use. This method of informality worked extremely well. It gave many a realization of the difficulties to be overcome, and made them more willing to cooperate. This was especially true when a pa-

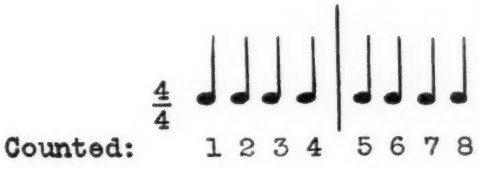


*Figure 1*

tient was asked to play an instrument which she had no desire to play, due to her ability or lack of ability, or the inclusion of a specific instrument for the benefit of the arrangement. More important, it gave each person a chance to feel she had contributed something to the music other than playing, and was an additional aid in drawing the patients outside of themselves.

An attempt was made to give each person a chance to play every instrument. As far as possible, instruments were changed with each new set of numbers. In some cases, especially with the better patients, this system was essential in order to maintain a good interest level. Those patients with the shortest attention span, though allowed to try any instrument, played the most simple instruments throughout, unless a change showed increased attention.

The main problem, which remained undefeated, was the limp fashion in which the patients handled their instruments. Even the most oriented patients seemed unable to grasp the instruments firmly and play with definite precision. Of the entire forty-seven, it can safely be said, no more than three patients were able to do so. This fault destroyed much of the tonal quality of the instruments, besides making the cut-offs regged. There was a slight improvement in some, by the end of the season, but it remained the main difficulty throughout.

The tempo of all numbers had a tendency to drag, and constant effort had to be put forth to keep it at its correct level. By the end of the season the tempo had improved, but it never reached a consistent level. The changing of instruments (some arrangements called for changes in the middle of the music) and the switch from one section's playing to another could not be done when the tempo was fast. Performing for an audience did not affect the patients, tempo to any noticeable extent. They usually did the best they were capable of doing which showed a maximum output of effort. Excepting in two instances (Fig. 3) manifestations of stage-fright were practically non-existent.

The short attention span of the average participant also created a problem. Certain patients never improved in this respect, but many, after finding they could actually play an instrument, and after being complimented on their performances by patients outside the band, gave more than their usual amount of attention. This is the only activity in which the instructor found she could leave the group momentarily and find everyone still seated upon her return. This was not true in the very beginning, but as the band

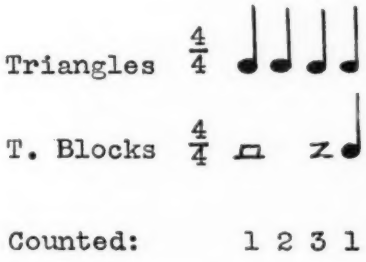


*Figure 2*

progressed this fact became more and more noticeable.

In the nine months period, there were thirteen numbers studied, and four performances given in the hospital auditorium. These performances were witnessed by other patients.

One classical piece was arranged and performed very well. Following this, others were suggested. But unanimously rejected in favor of popular music. Even with the popular there was a marked preference for the most simple numbers of the past and present day. This correlates so highly with the backgrounds of the average patients as recorded in their case histories, as to be an indicative factor.

Rehearsals were held three times a week and were of one hour's duration. If it was found

## Rhythm Band Statistical Chart

| Diagnoses | Patients Covered | Patients Unable To Reach Performance Level | Patients Not Interested | Percentage Not Retained | Patient's Interest Retained | Patient Home | Percentage Retained (or Home) |
|---|---|---|---|---|---|---|---|
| Dementia Praecox—Catatonic | 14 | 5 | 1 | 42.9 | 4 | 4 | 57.1 |
| Dementia Praecox—Paranoid | 8 | 1 | | 12.5 | 6 | 1 | 87.5 |
| Dementia Praecox—Hebephrenic | 5 | 1 | | 20.0 | 1 | 3 | 80.0 |
| Dementia Praecox—Simple | 1 | | | | 1 | | 100.0 |
| Dementia Praecox—Mixed | 1 | 1 | | 100.0 | | | |
| Manic-Depressive—Manic | 1 | | | | | 1 | 100.0 |
| Manic-Depressive—Mixed | 1 | | | | 1 | | 100.0 |
| Psychosis with Psychopatic Personality | 5 | | 3 | 60.0 | | 2 | 40.0 |
| Psychosis with Convulsive Disorders (Epilepsy) | 3 | 2 | | 66.7 | 1 | | 33.3 |
| Psychosis with Epidemic Encephalitis | 2 | | | | 2 | | 100.0 |
| Psychosis with Mental Deficiency | 2 | | 1 | 50.0 | | 1 | 50.0 |
| Psychoneurosis—Anxiety Hysteria | 1 | | | | 1 | | 100.0 |
| Primary Behavior Disorder | 1 | 1 | | 100.0 | | | |
| Psychosis associated with Orgainc Disease of the Brain | 1 | | | | 1 | | 100.0 |
| General Paresis | 1 | | | | | 1 | 100.0 |
| Total | 47 | 11 | 5 | 34.0 | 18* | 13** | 66.0 |

*Two rehearsed but refused to perform. (Manifestations of stage-fright?)

**Six went home while still members of the band.
Seven went home within four months after participation.

(Fig. 3)

the group was not very receptive the rehearsal period was shortened, if very receptive it was lengthened.

When a number was interesting and the patients were advancing to a point where the music sounded well, the number of arguments and temperamental outbursts noticeably lessened.

In conclusion: the following therapeutic aims, based on the ultimate removal of the patient's preoccupation with herself, were activated by this project:

1. Ideal socializing influence.
2. Concentrative powers in use almost constantly. (Increased attention span.)
3. Stimulus to mental and motor responses.
4. Feeling of accomplishment by presentation of a goal, both individually and as part of a group.
5. Creative relaxation from daily hospital routine.

List Of Music Played

1. Shoemaker's Dance
2. Norweign Dance
3. The One Rose
4. Indian War Brave Dance (from operetta "Dawn Boy".)
5. Along The Navajo Trail
6. Tico Tico
7. Easter Parade
8. The Merry Merry Month Of May
9. Roll Out The Barrel
10. Onezy Twozy
11. Doin' What Comes Naturally
12. The Old Gray Mare
13. Sioux City Sue

List Of Instruments

Temple Blocks
Tone Blocks
Clavis's
Rhythm Sticks
Castanets
Tambourines
Marracas
Cow Bells
Tom Tom's
Cymbals
Triangle
Tonettes
Ocarina
Glockenspiel

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*Rainy Day*—Young People's—$1.46.
*Funniest Song in the World*, by Groucho Marx—Young People's—$1.46.
*Young America*, by Lady in Blue (2 record Album)—$2.36.
*Magic Carpet*, by Lady in Blue (2 record Album)—$2.36.
*Bozo's Jungle Jingles*—Capitol—$1.31.
*Little Toot*, by Don Wilson—Capitol—$1.31.
*Songs for Children*—Tex Ritter (3 record album)—$3.95.
*Doctor Song, and Kitty-Katty* by Smilin' Ed McConnell—$1.05.
Teacher Song—*Funny Things*, by Smilin' Ed McConnell—$1.05.
*Backwards Song, and Me an I*, by Smilin' Ed McConnell—$1.05.
*Teddy Bear's Picnic, and Parade of Wooden Soldiers*—$1.31.
*Sleep Baby Sleep*, by Frank Luther—2 record album which includes *The Lord's Prayer*—$2.35.
*Genie, the Magic Record*, by Peter Lind Hayes (excellent!)—12 inch—$2.10.
*Babar, the Elephant*, by Frank Luther—12 in.—$2.10.
*Manners Can Be Fun*, by Frank Luther—12 in.—$2.10
*Little Tune that Ran Away*—Peter Lind Hayes 12 in.—$2.10.
*Songs of Safety*, by Frank Luther—12 in.—$2.10
*Shoemaker and Elves*, by Frank Luther—$1.30 (the above is very unusual in that the whole thing is done with music and in rhythms).
*Goldilocks*, by Frank Luther—$1.30 (Done in the same manner as above).
*Little Red Hen*, by Frank Luther—$1.30 (Done in the same manner as above).
*Nutcracker Suite*, by Fred Waring's Choir—12 in. (The whole thing is sung, and is perfectly lovely)—$2.10.
*Animal Polka* (tiny little animal voices)—$1.05.
*Happy Birthday* (with participation)—$1.05.
*Skip to my Lou*—$1.05.
*Party Record*—(Participating games)—$1.05.
*Peer Gynt Suite* (ages 5 through 8)—$1.95
*Picking up Paw-Paws*—$1.31.
*Fuzzy-Wuzzy Was a Bear* (very rhythmical)—$.98.
*I'm a Little Tea-Pot* by Two-Ton Baker—$.98.
*Everybody Has a Laughing Place*, by Two-Ton Baker—$.98.
*Choo-Choo Train Ride* (Excellent)—$.98.
*Playtime*—participation record with Jerry Bartell—$1.05.
*Playtime*—participation record with Jerry Bartell—2 records—$2.10.

*BREAKABLE RECORDS*:

*Tingo the Clown*, by Jerry Bartell—a 2 record album special at $.98.
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# NATIONALLY SPEAKING

*PRESIDENT'S ANNUAL ADDRESS*

The *Dynamic Forces in Occupational Therapy* are in operation. The Michigan Association has geared us to anticipate the best in *Engineering.*

It is pleasant to see so many of our members and friends present to witness and take part in the *Performance.*

We ask you all to kindly wear your badges. It will be a great help to the committee members, the conference workers, and the new members will be more quickly recognized. There may be a few strangers in our midst but certainly we hope there will be none by Thursday. Please introduce yourself and ask questions freely. You are most welcome at all sessions and we urge your participation in all social gatherings. It is only by frank and friendly exchange of opinions and ideas that we grow in professional stature.

Within the year our membership has increased, although the figures are not too impressive the increase is a substantial one which Miss West will report to you later.

Last year I came to you with a strong appeal for financial assistance in the form of increased membership and registration fees. You responded with confidence and I take this opportunity to thank you most sincerely on behalf of the officers, the Board of Management, and your national office staff. The reports which follow will show you the wisdom of your decision and the benefits that have accrued from your united effort.

In making grateful acknowledgement to those of you who promptly discharge your professional obligation I cannot help but feel chargin for those more than 800 occupational therapists who are in arrears in either or both registration and membership. They are probably not among us today so perhaps do not fully realize the advantages of keeping pace with professional progress. Some of you here may know one or two of these individuals who thoughtlessly neglect to keep in good standing in the association. The personal appeal of a friend might bring them back into the fold. Perhaps you can help to locate a member in arrears and influence her to become reinstated. Some of them are no doubt in remote locations and perhaps feel too far away to participate in national affairs. Possibly you could make them realize that just the Journal alone could keep them in touch and up with current events and the progress in occupational therapy.

The American Journal of Occupational Therapy is more than a magazine for each of us to enjoy. It is the mouthpiece of our profession to the allied medical and professional fields and to the public. We are pleased with it and proud of it's success to date. The possibilities of its further development are good. However, in addition to the excellent planning for promotion by the editor it will take the interest and assistance of our membership to accomplish the goals which Mrs. Murphy hopes to attain. Haven't you been impressed with the promptness of each issue this year? We would like to see more articles by occupational therapists. Many of you are doing very interesting and creditable things—won't you write about them so that we all may share your experiences? Also, tell us of your friends or associates who can furnish the Journal with valuable material. The advertising in our magazine can become a valuable asset only as you patronize the firms and products listed there. Many of the advertisers are here with their merchandise in the commercial exhibits. You will want to see all of them. Our first venture into commercial exhibits last year at New York was enthusiastically received. Therefore it is hoped we may continue to have these exhibits at each annual meeting in the future.

The program of our educational office, about which we were concerned financially a year ago has fortunately been able to carry on without interruption. In this connection we wish to commend the fine cooperation which the directors of the clinical training centers have given by their patient and thoughtful completion of the many questionnaires sent to you. These were necessary in order to compile the factual information to continue the various studies in progress in the education office. Miss Otto and our consultant want you to know how very much they appreciate your genuine interest and the effort involved. We all recognize that the educa-

tional and research studies can only succeed in so far as you are willing and able to furnish them with the data concerning the assets or advantages, as well as the lacks or delinquencies, in our present educational system of training occupational therapists.

You have previously been informed that the Kellogg Foundation of Battle Creek, Michigan, last fall extended their support to the Education Office for two more years. The first payment of $10,000 was received in November and was literally the salvation of our education program. The previous grant had been entirely expended, and the general fund balance was barely enough to carry the executive office until your fees became due in January. Now after a three year struggle our Treasurer will proudly present a much more optimistic picture.

This fall we anticipate the last payment of $8,000 from the Kellogg Grant so that a year from now we must as an organization resolutely face the obligation of financing our own educational office. To do this we must plan to allocate a portion of our funds each year for this purpose. For the first time we can see our way clear to do so by a transfer of funds from the general office account. I wonder if you all realize that Kellogg Funds have actually maintained our education office since its inception.

It is only through the proof of the ability of any association to maintain itself that it can hope to obtain grants for special projects, such as scholarships, research, specific studies, etc. The Kellogg Foundation has made our education office possible. The most significant result has been the estabilshment of our examination and registration system of which you may be justly proud for it is highly regarded by other professional groups.

As during the past year, the ensuing year will be concerned with

1. Building basic curriculum.
2. Improvement of existing training facilities.
3. Accrediting of occupational therapy departments.
4. Establishment of student selection instruments and subsequently the analysis of these studies.

Further aid and confidence has been given to our educational program by an appropriation from the Grant Foundation. It was obtained through the initiative and presentation made by Miss West. She investigated the source and solicited the donor. With the assistance of Miss Otto and our consultant the plan was developed and gained the approval of the Grant Foundation for $21,000. Miss Otto will later outline the purpose for which the grant will be used.

These experiences bring us to the realization that any such funds are given only for specific purposes and are always so earmarked with limitation of time for completing the work. Consequently, while of tremendous value in accomplishing a given project, the funds do not and cannot provide the means to maintain general educational investigation or development. Therefore, we still must build and maintain that back log of security for our educational office. This, we are now able to start.

Recruitment is perhaps one of the greatest and immediate needs. Miss West's report and that of the Education Committee will point out the present situation and the prospects of filling the demand for qualified occupational therapists within the next few years. To assist in recruitment of desirable candidates for training, a special committee on Recruitment and Publicity has been appointed with Miss Susan C. Wilson as chairman. Each state association is asked to aid in this program by appointment of a local recruitment and publicity chairman and committee to work with the national committee. The occupational therapy schools will participate by assisting in the plan to develop more adequate vocational guidance in the schools and colleges in order to interest students for occupational therapy training.

The serious shortage of qualified therapists to fill the existing vacancies is a serious threat to our profession, simply because we are not accomplishing our purpose in several of the specialized fields. In addition to increasing our members it is very important that those of you now active in the field take advantage of every opportunity for further study in advance specialization. There are fine positions available for which we cannot name adequately qualified therapists. The association will continue to seek ways and means to provide scholarships for you. Further preparation means greater opportunity. Your national office was dissappointed in the small number of applicants that applied for the graduate course at the University of Southern California this summer and only three occupational therapist applied for the course at Warm Springs Foundation.

An effort will be made to obtain scholarships on the various educational levels if you want

them. We believe it can be done but there is little incentive for the Association to pursue these opportunities unless there is a demand for them among our members. Perhaps you can suggest to our office and your schools which courses and areas of study would be most helpful to you in your particular field of endeavor. We welcome your ideas!

The annual reports of the work of the Special Committees will be printed in A.J.O.T. Nevertheless I would like to give you a brief account of these important accomplishments.

The Special Committee on Poliomyelitis, Sue Hurt Gibbs, Chairman, was instrumental in securing these scholarships through the National Foundation for Infantile Paralysis and the Warm Springs Foundation. With this fine mission accomplished Mrs. Gibbs has resigned. The functions of this special committeee being chiefly educational will henceforth be handled by our education office.

The Special Committee on Establishment and Operation of Occupational Therapy Departments, Margeurite Abbott, Chairman, has Section I of the Manual ready for committee action. When completed this work will fill a real need for therapists and department directors, hospital superintendents, and administrators.

Our Rules and Procedures Committee with Sister Jeanne Marie as it's brilliant and indefatigable chairman, made an exhaustive study of the history of service of the six standing committees from their beginning. From this study a basis of reference was established from which a Manual on Committee Procedures has been completed. It will be used as a guide to the proper function of association committees.

To supplement the work of registered therapists eleven states have conducted Volunteer Training Courses. The report of the Chairman of the Occupational Therapy Volunteer Assistants Training Courses, Mrs. Edgar D. Oppenheimer, records 115 volunteers trained and placed in Voluntary, Veterans, and Municipal Hospitals from New York to the State of Washington. The instruction is provided by registered occupational therapists who give of their own time to train these auxiliary workers.

The Six Standing Committees of this Association are a vital force in our professional achievement. A great deal of our progress is due to the diligence and ceaseless application of these committee members. The chairman of each committee will follow with the report of her group. We cannot measure in time or money, the effort and sacrifice that these occupational therapists render in the way of service to our profession. It is an entirely voluntary service for which we owe them a deep debt of gratitude.

In closing I wish to acknowledge with sincere appreciation the confidence and support which you all have given me during my term as your President. The cooperation and service of the Committees, the Board of Management, the House of Delegates, and the membership at large has been most gratifying. It has been a rich experience for me. Particularly do I wish to apprise you of the fact that whatever progress or success we as an association have made is due to the fine and efficient professional staff in your national office. It is they who motivate and coordinate our activities. They have broadened our horizon and are able to meet our future problems with courage and confidence. Miss West, executive director, and Miss Otto, educational field secretary, we thank you sincerely.

## *ANNUAL REPORT OF THE EXECUTIVE DIRECTOR*

The year that has passed since our 1948 annual meeting has been more significant and gratifying than it will be possible to tell you in this report. By taking you inside the AOTA for a few minutes, reviewing the main events of the year, and adding some interpretation made possible with the perspective of time, I hope to have you experience some of the satisfaction and inspiration it has been for me to spend another year in a position where I may observe the overall progress of our profession.

The year started inauspiciously but your interest and support have increased steadily since that time. The Treasurer's report will give you details in this matter, but I cannot resist the opportunity to express thanks to every one of you for responding so nearly unanimously with renewed support. Only this has made both more extensive activity and thus greater achievement possible. For with a substantially increased income, at the same time maintaining a safe restraint on expenditures, more of our plans have been effected and fewer are left on the "pending finances" list. Inevitably, this has

meant, and will continue to mean, a proportionately greater return to all of us in the advancement of our profession.

There now follow brief reports on the various activities with which the National Office is concerned.

The membership and registry to date show that we have recovered from both the post-war slump and its subsequent plateau to show a healthy and steady growth. Our total registry now numbers 2839 and our membership 2761. These figures would be increased to over 3300 registered occupational therapists and over 3500 members if those who are behind in payment of dues and fees were counted in as they have been in previous years. Although some reinstatements from among these numbers are anticipated, their inclusion in annual statistics is not warranted. We are therefore still below the 3000-mark we should now be exceeding. Marriage is still our greatest professional threat, though the happy reward of many individual OTs. It is reassuring that though many leave our ranks, it is usually for just cause and but rarely for dissatisfaction or unemployment.

This brings us to the placement situation. There has been a considerable increase in the total number of persons requesting job referrals from the National Office and a consequently larger number of placements effected through this service during the past year. The number of unfilled positions, however, has continued to exceed the number of available personnel, and opportunity remains at an all-time high. This is a positive value for recruitment but an unstabilizing factor within the profession since it leads to excessive "shopping around" and a too-frequent rate of change. This is indicated by the following figures: Three hundred and eleven occupational therapists have requested jobs and three hundred and twenty-five agencies have listed a total of four hundred and seventy-eight vacancies with the National Office during the past year. (This apparent overlapping is accounted for by the existence of multiple vacancies in several institutions.) In comparison with those requests, however, only eighty-one placements are known to have been effected through the National Office during the past year. Although this figure represents a 31% increase over the total number of placements made in any previous year, it still seems small by comparison with the effort expended. This is made evident when we consider that over 2500 referrals were made to the 311 therapists and nearly 2200 therapists were named to the 478 vacancies. In addition, 162 job lists were sent out during the year. We are forced to conclude from these figures that with the small percentage of follow-through, there is much effort wasted.

Far greater emphasis must be placed on the importance of service in psychiatric hospitals and the growing need for personnel in this field. Nearly half the current graduates are taking positions in physical disabilities, which of course is gratifying to those interested in the newer specialties of cerebral palsy, poliomyelitis and others. The remaining half, however, are not enough to spread more than thinly over the other important specialties. With the majority of hospital beds occupied by psychiatric patients, we must not so deplete our numbers in this field as to force the indiscriminate use of untrained personnel in active treatment programs, a substitution which is already more than a possibility. To avoid such, the National Office has been actively engaged in assisting local groups in raising salaries in the state service with considerable success in at least two instances. This effort must be followed through on the state level by better defining of Civil Service Classifications, by distinguishing between professional and sub-professional qualifications and by taking other steps which will increase the attractiveness of psychiatric work. Meanwhile, school and clinical directors must see that students receive fair orientation and exposure to good psychiatric training. Until these things have been done, it will not be possible to enlist the number of graduates needed, nor will it be easy to recruit new candidates for the profession as a whole.

Increased recruitment is a subject which requires little development among occupational therapists since it is a chronic need which we have publicized extensively during the past year. You are aware of the constantly growing need for personnel in the clinical field; this and the additional fact of below-capacity enrollments in many of the schools have made a more active recruitment effort necessary. Even those schools who have less of an enrollment problem could enjoy and profit by a more comfortable margin of selectivity made possible by greater numbers of applicants for training.

Publication of the new brochure, "A Career of Service in Occupational Therapy," has done

much to spread among potential recruits information about the profession, the required training, and the opportunities in this field. Forty thousand of these pamphlets have already been distributed from the National Office with the assistance of schools, state associations and individual members. Response to this single effort has been most gratifying, both from you who aided it and from the inquiries it has elicited. One of the most interesting and recurring requests received in this connection has been for the addresses of occupational therapy departments which might be visited by prospective students wishing to familiarize themselves with the work of the therapist and the requirements for training. This more thorough investigation of the field in advance of enrollment for training should reduce the numbers choosing our career under false impressions.

These and other efforts have aided recruitment, but much remains to be done. More of us must assume personal responsibility for intensifying our total recruitment effort. This means taking on speaking engagements, contacting guidance personnel and getting literature into libraries, schools and colleges. Those of you who have been hesitant to undertake these duties with little or no material to back you up will be interested to know of plans to remedy this difficulty. In cooperation with similar groups, such as the physical therapists, speech therapists and special education people, we hope this Fall to start a three-phase, long-range program. The first project will be the development of a guidance counselor's manual; the second, production of filmstrips; and third, publication of a handbook of sample speeches, radio scripts, career-day talks, etc. With these materials in hand, or available for direct distribution, it should not be difficult for you to help us make our profession better known and more widely sought.

In the foregoing, I have indicated our principal problems among routine activities. They comprise only a part of the picture, however, since our continual development and expansion have brought numerous other associations and responsibilities. These are concerned with our professional growth.

Essential to such is the extension of training opportunities and the improvement of training standards. Deterrent factors in recruitment are the length and cost of training for occupational therapy. Professional training, which must be preceded by a minimum of two years general education, is beyond the financial means of numbers of qualified and highly desirable candidates. With constantly increasing tuition and maintenance costs, undergraduate education for our profession has therefore become prohibitive for many. In Congressional legislation now pending, the omnibus health bills provide for grants-in-aid to schools and stipends to individuals for training in medicine, dentistry, nursing, and the ancillary medical professions. In an effort to avoid further handicap to recruitment which would occur if similar professional fields were subsidized to the exclusion of occupational therapy, the National Office requested the privilege of presenting occupational therapy's testimony for inclusion with those fields to be given such aid. We were granted opportunity and, early this summer, presented testimony before the Senate Committee on Labor and Public Welfare. It included a total picture of the developments in the profession, with particular respect to training, and the needs for the future. Our case was favorably received and is now incorporated in the Congressional Record. If we are still a part of whatever legislation is ultimately passed, problems of recruitment and increased school enrollment will be considerably alleviated by enabling larger numbers of students to undertake training. Grants-in-aid to the schools will also permit the improvement of training through additions to faculty and staff, physical plant and facilities for clinical training.

On the graduate level, we have also been concerned with educational opportunities. As has previously been reported to you, we have requested funds under the National Mental Health Act. These are also sought for both schools and students; for schools to develop a graduate course in psychiatric occupational therapy and therapists to take such courses. The importance and value of getting such aid are obvious. We are almost certain it will be given but cannot speed the process through which federal grants are made. It is hoped, however, that such opportunities will be available in the 1950-51 academic year. It is likewise hoped that, when available, there will be many among us who will be quick to take advantage of them. you are already aware of the scholarships offered by the National Foundation for Infantile Paralysis for graduate study in poliomyelitis and by the National Society for Crippled Children and Adults for specialization in cerebral palsy. Ef-

fort is constantly being made to obtain further assistance from organizations like these who use occupational therapists' services and who would benefit by their better preparation. We are hopeful that the coming year will see an extension of available opportunities of this type.

Meanwhile, as always, it is important that we maintain relationships and contacts with these and similar groups and extend our cooperation to other allied agencies. To this end, our organization was represented during the past year at the annual meetings of the American Medical Association, American Psychiatric Association, American Congress of Physical Medicine and Rehabilitation, and American Physical Therapy Association. We also participated in the First National Conference on Cerebral Palsy as we did the previous year in the First International Conference on Poliomyelitis. That occupational therapy was a vital part of these important meetings, both in scientific papers and technical exhibits, is tangible evidence of our advancement and acceptance. In addition, extra meetings with representatives of these and other organizations have been held for the planning and promotion of mutual interests in educational, administrative and treatment programs. Finally, our AOTO exhibit has this year been shown at nine occupational therapy schools, at several colleges, and at various regional medical conferences for recruitment or interpretational purposes.

Meanwhile, it has been thought vital to continue our Education Office and we have therefore been active in conducting a research program and in securing funds for that purpose. It was necessary this past year to present an entirely new proposal to the Kellogg Foundation to continue support of this comparatively new program. You are already familiar with the scholarships and loans, the appropriation for publicity, and the original three-year grant for establishment of the educational research program which have been responsible for professional benefits we could not have realized by ourselves. On the basis of a special request for continuation of this support, the Kellogg grant has been extended. This additional appropriation will make it possible to complete standardization of the national registration examination, and to continue and conclude numerous other research projects begun in the past three years.

We also approached the Grant Foundation this past year for assistance with a special education project. Their appropriation of $21,000 over a three-year period starting September, 1949 will be used for the development and implementation of student selection instruments for occupational therapy. It is hoped that the ultimate use of these measures by occupational therapy schools will assure greater success in the selection of candidates sincerely interested in and well suited to the profession.

Our success in acquiring funds from the Kellogg and Grant Foundations as well as from the National Foundation and the National Society for support of projects outlined above leads us to hope that we may secure funds for other purposes in the near future. Subsidy of undergraduate and graduate training, educational research, publicity, the development of visual aids and similar projects are all necessary to our future professional growth, and could be made available to us. It must be recognized, however, that funds for these purposes can be obtained only with a great expenditure of time, effort and extensive planning. Our experience has been that at least one calendar year is required from the inception of the project to the actual grant of funds if such a project is deemed acceptable by the foundation.

While we have been engaged in the varied activities described above, we have not forgotten the problem of a means of communicating information about these activities to you. To this end, we instituted during the past year a section of our magazine called "Nationally Speaking." Through these bi-monthly reports from the President and National Office personnel, we have tried to bring you news notes, studies, analyses and reports on items of national activity for the purpose of making you a better-informed membership. This coming year, starting in September, we will re-establish the AOTA News Letter which will also be pulished bi-monthly, alternating with AJOT. We hope it will prove to be another means of keeping you more closely in touch, and of making you feel that you belong.

Our Occupational Therapy Yearbook, or Directory of registered therapists, is another item which may be included here under the general heading of communication and in which there will be a change next year. You are already familiar with the new format, and we hope that you have liked it and found it helpful. The changes and the increased advertising will make

it possible to publish a complete Directory each year rather than having a supplement only in alternate years.

This completes the report on our national activities. I began it by telling you that the year started inauspiciously. I'm more than happy to be able to say that the trend changed at an early date, making possible a different end to the year and thus to this report. Your increased support has made a world of difference in budgeting the year's expenditures, being able to maintain an adequate office staff and doing things on schedule. Thus, our outlook for the coming year can be both broader and more positive. It can continue that way if you continue your support. We look forward to working with you throughout the coming year with correlated effort in our mutual interests and with increasing achievement of our common aims.

Respectfully submitted,
Wilma L. West, OTR
Executive Director

## *ANNUAL REPORT OF THE EDUCATIONAL FIELD SECRETARY*

For the Education Office, as for all of you, the year 1948-1949 has been a busy and productive one. At times it has seemed that progress was slow. In review, however, it is a great satisfaction to report that most of our aims have been accomplished. The educational research program, which we all realize is basic to the sound development of our profession, is forging steadily ahead. As you may know, this program, planned with vision by previous Edcational Field Secretaries, was initiated in 1946. It has been supported with interest and confidence by the Board of Management and financed by the Kellogg Foundation. This report is to give you an over-all view of the progress of the educational research program during the last year, of the other activities of the Education Office, and of our plans of accomplishment for next year.

Two projects included in the original three-year educational research program were completed. Project one is the Activity Survey, with which most of you are familiar since questionnaires were sent to all occupational therapy departments in the country known to the National Office. Our purpose in conducting this survey was to obtain an accurate picture of therapeutic activities currently employed in the treatment program of occupationaly therapy departments. Such data it was felt, would provide occupational therapy schools with reliable information as to the skills to be emphasized in the preparation of students to meet the demands of clinical practice. Of the 700 questionnaires sent out in July, 1948, 410 were answered and returned to us. This is an unusually high percentage of response and your fine cooperation is greatly appreciated. A report of the results was completed in May of this year and sent to all occupational therapy school directors and to the 410 respondents. This summary furnishes specific information on the frequency of use of 70 different activities, their treatment purposes, their use with the different age ranges of patients, limitations in their use imposed by lack of physical facilities, and the adequacy of student preparation. The activities most frequently used in our treatment programs are reported to be leatherwork, cordknotting, woodworking and weaving. It is also interesting to note that weaving is employed most frequently for physical purposes and typing is used most frequently for prevocational purposes.

These are neither new nor startling discoveries. The value of the information however, is that it presents an objective analysis of current practice and confirms what has been previously surmised but not proven. The report should give both reassurance and information for curriculum planning to those who are preparing students. It also presents us with an opportunity and challenge to take a look at ourselves, to decide whether we like what we are doing, whether we want to continue using the same treatment media and whether we want to consider the introduction of new media. (Copies of this report may be ordered from the Education Office.)

The construction of the Performance Report Form was the second project completed this year. Again, many of you are familiar with the project since you may have been asked to complete the forms and since it has been discussed in recent issues of AJOT. To review, briefly, the form was developed with the help of a large group of therapists in the clinical field. Its purpose is to obtain ratings on first year job performance of therapists who have taken the new type of registration examination. The rat-

ing of each therapist is compared with her (his) rating on the examination to determine the relationship of performance on the examination to performance on the job. A total of 381 copies of the form were mailed to occupational therapy department directors or superintendents of hospitals employing first year therapists. Of these, 267 were returned. The result of the comparative analysis of these ratings will be presented in the Registration Committee report. Here, we again wish to thank you for your excellent response.

A project started by the Education Office during the year but not quite completed as yet is the revision of the Student Clinical Training Report Form, Director's and Rater's Guides and Interpretational Key, at present being used by all those training students. These materials were, as you know, developed by the Sub-committee on Clinical Training in cooperation with the Education Office in 1947. They were put into use in January 1948 on an experimental basis for one year with the proviso that they be re-evaluated at the end of that time and subsequently revised if necessary. Questionnaires to obtain information on the clarity, inclusiveness and use of these materials were developed this year and sent to 220 clinical training centers and 25 school directors for completion. A total of 103 were returned from clinical training directors and 15 from school directors. A summary of the information received from the completed questionnaires has been submitted to the Sub-committee on Clinical Training for inclusion in the revision. When completed and approved, the revised Clinical Training Report Form, Guides and Interpretational Key will be sent to all clinical training and school directors. We hope to accomplish this by the end of this year. A great deal of credit and thanks should be given to members of the Sub-committee on Clinical Training for their fine and extensive work on this project.

Three other projects of the educational research program have been carried on mainly by committees, with some assistance from the Education Office. These are: the development of a Student Manual; the construction of a Curriculum Guide; the establishment of procedures for evaluating occupational therapy departments. Encouraging progress has been made in all three projects.

Continuing responsibilities of the Education Office are 1) the revision and semi-annual administration of the registration examination and 2) the development of graduate study opportunities.

1. The work connected with the registration examination involves item by item preparation, arrangement for administration under as many as 36 different proctors located all over the country as well as abroad, and scoring and item analysis for revision. A report of the excellent and loyal work of the Registration Committee will be given later this morning.

The new type of examination has now been given six times over a period of three years and the Registration Committee is concerned about safeguarding its content. Work on an alternate examination has therefore begun. Preparatory to this, O.T.R.'s representing all the areas covered by the examination were asked to write new examination items. While the response to this has been good, new items will constantly be solicited in order to provide for both the new exam and the item pool from which replacements are made.

As important as safeguarding of exam content, is assuring that the content keep pace with improvements in curriculum patterns in occupational therapy schools. All school directors have therefore been asked to report changes in curriculum outlines originally prepared for the construction of the 1947 registration examination and used as instructional guides since then. Changes will be incorporated in standard outlines and future examination revisions will be based on these outlines.

In order to assist curriculum evaluation and student selection, a summary of the performance of all students on the first four new type registration examinations given in 1947 and 1948 has been distributed in graphic form to all schools. Code numbers were used to indicate the standing of the students of every school in relation to those of other schools for each of the four examinations and for the four examinations together. An analysis of the examinee's answer in the various areas of occupational therapy covered by the examination was also given to each school. This information is intended to assist schools in evaluating their instructional patterns for each area of the curriculum.

2. The Education Office has sought to develop graduate study opportunities under the National Mental Health Act. Several meetings were held with representatives of the United

States Public Health Service to plan for graduate training of the occupational therapist working with the psychiatric patient. Objectives and curriculum content of such training, criteria to be met by occupational therapy schools applying to the Advisory Mental Health Council for support in establishing such a program, and eligibility requirements for scholarship applicants were developed. As reported by Miss Wilma West, this whole matter is still under consideration by the Council and contrary to our hopes, we are as yet unable to report anything definite.

The Education Office has also worked with the Special Committee on Poliomyelitis in the selection of an arrangement for the twelve recipients of the National Foundation for Infantile Paralysis scholarships for the four week polio course given this summer at the University of Southern California. Announcement of this special grant by the National Foundation for these scholarships was made last year. The reports from California have been most enthusiastic about the value of the course. It would be well to watch future issues of AJOT for a possible repetition of this opportunity at the University of Southern California.

As previously announced in AJOT, scholarships from the National Foundation for Infantile Paralysis are now also available to occupational therapists for graduate study in the care of the poliomyelitis patient in centers listed by the Foundation. Two such courses may be applied for at the present time. We have been asked by the National Foundation to take part in the selection of candidates for the two courses at Warm Springs and at the University of Colorado Medical Center.

One very important project of the educational research program which is to be initiated directly after the Convention, is the development of instruments for student selection. Those in the educational field have long felt the need for specific measures for the selection of occupational therapy students. The use of "tailor-made" instruments—that is, tests constructed specifically to predict the suitability for and probable success in training, are therefore contemplated. Our first approach will be the construction of measures of personality and interest. A plan for this project has been developed and work will start on it this Fall, under the Grant Foundation appropriation.

This ends the report on the educational research program. The Education Office, however, has other aims and interests besides those mentioned under the research program. The following are a few examples.

In September, 1948 the Clinical Training Pool, planned by a special group of the Subcommittee on Clinical Training was established in the Education Office. The pool is to take care of unexpected needs of schools for clinical training openings and to assist clinical training centers in maintaining their quota of students. A total of 165 vacancies for different periods of student training were listed with the Education Office during the year. The majority of these are in psychiatric hospitals with the general, orthopedic and tuberculosis hospitals following in that order. Only five requests were received from schools. This indicates that there are at present far more clinical training vacancies than there are students to be placed. With the expected increase in enrollment, however, this situation should gradually become more equalized.

Inquiries have been received regarding the establishment of a curriculum in occupational therapy in affiliation with a university or college from California, Oklahoma, Pennsylvania, Wisconsin, and Puerto Rico. Guidance in requirements and procedures was given in all instances. Such guidance took into account that 1) the existing 25 schools are adequate for those seeking admission in all parts of the country except in the deep South; and 2) such a course must have a specialized instructional staff and local clinical training facilities in order to be accredited by the American Medical Association.

Requests for information on requirements for training, length and type of courses, future of occupational therapy as a profession, etc., are received constantly, in person and by mail. For example, the publication of an article on occupational therapy in two high school papers brought us inquiries for information from over 400 young people. Applicants who are too far away from their school of choice to arrange conveniently for an interview with the school director are interviewed by the Educational Field Secretary and a report is sent to the school.

Other responsibilities falling under our jurisdiction are surveying the need for occupational therapy institutions considering the advisability of establishing an occupational therapy department, and planning for the National Institute

in cooperation with the local Institute Committee. In connection with this a Standard Operating Procedure was developed during the year as a basis for all future Institute planning. Meetings are also being held with representatives of the Congress of Physical Medicine and the Physical Therapy Association for the purpose of discussing educational objectives and procedures.

One other activity which deserves mention is the preparation of detailed reports of the present program of the Education Office and of plans for future projects for presentation to the Kellogg and Grant Foundations prior to receipt of appropriations. We are indeed fortunate to have had funds which have enabled us to contribute to our continued professional development through an active program of educational research.

In closing I should like to express sincere gratitude to the President, Executive Director and Board of Management of the American Occupational Therapy Association for their belief in and support of the Education Office and its program, to Dr. Hyman Brandt who has directed our program with vision and skill, to chairmen of Association committees, to the many committee members who have given generously and unselfishly of their time, knowledge and experience, and to all those who have shown their interest in our program by completing time-consuming questionnaires and thus giving us the information essential to our studies. Your continued support is needed and appreciated.

Respectfully submitted,
Eva M. Otto, OTR
Educational Field Secretary

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The National Society for Crippled Children and Adults will hold its annual convention November 7-9 at the Commodore Hotel, New York City. Delegates from 2,000 state and local affiliates of the National Society will discuss research, rehabilitation, training, and treatment for the handicapped.


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# PEOPLE YOU SHOULD KNOW

WINFRED OVERHOLSER, A.B., M.D., Sc.D.
*Superintendent, St. Elizabeth's Hospital*
Washington, D.C.

A Biographical Sketch
by
ARVILLA D. MERRILL, O.T.R.
*Chief Occupational Therapist*
St. Elizabeth's Hospital
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Winfred Overholser was the first of three children born to Mary J. (Walker) and Edwin M. Overholser on April 21, 1892 in Worcester, Massachusetts. His father, a successful business man dealing in surgical supplies, moved to Worcester from Lancaster County, Pennsylvania, about 1880. The first Overholsers came to America in 1728 from Switzerland in the hopes of finding a community in which they could live and have freedom of religious beliefs.

His early education was received in the public schools of Wellesley, Massachusetts, and he entered Harvard in 1909, graduating cum laude in economics with the class of 1912, entering Boston University School of Medicine in the fall.

While attending medical school he lived in what is now the Massachusetts Memorial Hospital and enjoyed the association of many outstanding physicians. One of the most prominent neurologists and alienists in Boston at that time was Dr. Frank C. Richardson, head of the Evans Memorial Hospital, who took a special interest in young Overholser and was able to give him many extra opportunities not afforded the other students to see neurological and psychiatric cases. This influence added to his already well formed convictions that psychiatry was to be his carrer. Dr. Overholser received the degree of M.B., in 1915 and M.D., in 1916 from Boston University School of Medicine.

Dr. Frank C. Richardson's continued interest made it possible for him to remain an extra year as his resident physician and provided Dr. Overholser with many stimulating opportunities to read psychiatric literature and to attend numerous clinical demonstrations at a time when the diagnosis and treatment of psychotic disorders were being debated by such prominent men as Morton Prince and E. E. Southard. His thinking was influenced by such important persons as Dr. George M. Kline, later president of the American Psychiatric Association, who had just been appointed Commissioner of Mental Diseases and Dr. L. Vernon Briggs, a forceful figure in psychiatric progress, who secured the passage of the famous "Briggs Law".

Upon completion of his residency (one year) at Evans Memorial Hospital, Dr. Overholser joined the staff of the Westboro State Hospital. With the declaration of war he entered theArmy of the United States in February, 1918 and was commissioned a first lieutenant. He was ordered to the Neurological Institute in New York City for further training in a military program, then transferred to Camp Upton and later sent overseas with an evacuation hospital established at Vaubecourt, France. After a short tour of duty in this hospital he was transferred to Base Hospital No. 117 at Prez sous La Fauche, which was the main center for treatment of psychoneurotic soldiers. A note from his diary at this period reads: "We are trying to treat psychoneurotics according to the Order of the Day. We have managed to set up a primitive sort of

psychotherapy. We are using suggestion and hypnosis when it is possible. Time is on our side and some of the patients get well in spite of us". Upon his return to the United States following the Armistice, he was assigned to an Army General Hospital in East Norfolk, Massachusetts (now the Pondville State Hospital) where psychotic veterans were being treated. He was released from the army during the summer of 1919.

On June 4, 1919, Dr. Overholser and Dorothy Stebbins of Worcester, Massachusetts were married. With his former staff position available he took his bride to Westboro State Hospital where they stayed one year. He was transferred to the Gardner State Colony in 1920 as assistant superintendent and in 1921 moved to Medfield State Hospital. He gained recognition and support from his superiors for his successful endeavors in the problem of improving the care of the patients. He organized and was a member of the hospital orchestra. Dr. Overholsers' interest in occupational therapy dates back to this period when as a hospital administrator and later in the office of the Commissioner of Mental Diseases he was able to observe occupational therapy techniques in action. As a personal friend of Marjorie Greene, President of the Boston School of Occupational Therapy, he has had an opportunity to learn about many of the problems and watch the development of the profession. While at Medfield he maintained an interest in community affairs and was also Commander of the local American Legion Post.

The appointment of Dr. Overholser as assistant to the Commissioner of Mental Diseases, Dr. George M. Kline, in October 1924 was due in a large measure to his outstandingly successful work in the improvement of state hospitals in Massachusetts. In this capacity he was able to visualize the entire state hospital program as seen from the central office of the State House in Boston. A great deal of emphasis was given to the importance of mental illness in relation to crime and Dr. Overholser was appointed director of the division for the examination of prisoners, aimed primarily at bringing the advantage of psychiatric examination to mentally ill prisoners in the county jails. His writing career in the field of forensic psychiatry was begun at this time.

His interest in teaching was evidenced by the positions as Instructor in Psychiatry at the Boston University School of Medicine from 1925-1926; Assistant and Associate Professor, 1926-1934, and Professor from February to September, 1934. He lectured at the Boston University School of Law from 1929-1937.

In 1930 he was appointed Assistant Commissioner of Mental Diseases for the Commonwealth of Massachusetts. Following the death of Dr. Kline and the desire of Dr. James V. May, his successor, to return to the Boston State Hospital, Dr. Overholser was appointed Commissioner of Mental Diseases by Governor Joseph B. Ely in June, 1934. He served in this capacity for two and one half years when, in spite of his wide experience and general recognition of his ability to fill this position, the then Governor, James Michael Curley, refused to reappoint him. His successor was later removed after a chaotic year in office during which hard-earned gains in the state hospital system were lost. Dr. Overholser's work in promoting the operation of the "Briggs Law" has been of outstanding value.

During Dr. Overholser's residence in Massachusetts he held the offices of secretary, vice president as well as counselor of the Massachusetts Psychiatric Society, and is an honorary member of the society. He was also president of the New England Society of Psychiatry in 1936.

In May, 1937 he completed a survey of the research facilities in mental hospitals for the National Committee for Mental Hygiene.

The position of superintendent of St. Elizabeth's Hospital in Washington had been left vacant by the death of Dr. William Alansen White. The Honorable Harold Ickes, then Secretary of the Interior, requested that a committee of prominent members of the American Psychiatric Association be appointed to advise him in the selection of a successor for Dr. White. Three names were submitted and shortly thereafter Mr. Ickes announced the appointment of Dr. Winfred Overholser as Superintendent of St. Elizabeth's Hospital.

When Dr. Overholser took over these duties there were military and civilian patients in this hospital. During the war period St. Elizabeth's cared for over five thousand naval officers and enlisted men as patients. In addition, about one hundred and twenty five naval medical officers and nearly one hundred nurses were given instructions in psychiatry and approximately eight hundred corpsmen received training. Re-

cently the Surgeon General has recognized these services by awarding a certificate of Achievement to St. Elizabeth's Hospital and a Certificate of Appreciation to Dr. Overholser. He also received a War and Navy Department Commendation for his services to the Office of Scientific Research and Development during the war. As a member of the psychiatry advisory committee of Selective Service throughout the war he was awarded the Selective Service medal in 1946.

In 1940 the hospital was transferred by the President's Re-organization Plan from the Department of the Interior to the Federal Security Agency. Dr. Overholser has maintained the high medical standards that Dr. White had set and has developed a widely recognized teaching program. Physicians from South and Central America are receiving short courses in modern psychiatry and are thus exposed to the American viewpoint in this field. The hospital maintains a School of Nursing and the graduates of this school have consistently taken highest grades in examinations set by the Nurse Examining Board of the District of Columbia. Post-graduate courses for medical, nursing, psychological, theological, social service and occupational therapy students are offered under his guidance as well as several courses given periodically to the attendant personnel.

St. Elizabeth's Hospital military tradition extends back to the Civil War. However, in 1946, the law was changed to exclude the Army and the Navy from its benefits, much to the regret of both the hospital and the Navy. Although a number of veterans remain under treatment it has become more of a civilian hospital.

Dr. Overholser was appointed professor of Psychiatry at George Washington School of Medicine in 1938, in which capacity he serves at the present time. He is also a lecturer in psychiatric jurisprudence in the Washington School of Psychiatry. In 1940 Boston University conferred upon him the honorary degree of Doctor of Science. On June 4, 1949 he received an Award of Merit for Distinguished Public Service from the same University.

Among his extra-curricular assignments was his appointment as a member of the Federal Board of Hospitalization on which he continued to serve until the board was reorganized by the Bureau of the Budget in 1943. He has served as a member of the Medical Advisory Council of the Veteran's Administration and on the advisory committee of the neuropsychiatric division of the Veteran's Administration. He took an active part in the establishment of the Research Council on Problems of Alcohol and served on the executive committee and as chairman of its scientific committee after coming to Washington. In 1941 he was appointed a member of the Advisory Council on Gerontology in the National Institute of Health under the Public Health Service. Dr. Overholser has been interested in this subject for many years and his bibliography contains several articles on problems connected with psychiatric problems in the aged.

In 1940 Dr. Overholser was made chairman of a committee on neuropsychiatry which was set up by the National Research Council in an advisory capacity to the Surgeon General. Early in 1942 he was able to organize an occupational therapy section where perhaps his greatest contribution to this profession was given. He was able to bring to the attention of the Surgeon General the importance of occupational therapy as a profession on an equal basis with physical therapy and from his foresight and wisdom grew the present status of occupational therapy in the Army.

When the American Medical Association established the journal, *War Medicine*, Dr. Overholser was appointed on the editorial board and served until that journal was succeeded by *Occupational Medicine* in 1945. He has since served on the editorial board of the latter journal. He is currently Editor-in-Chief of the *Quarterly Review of Psychiatry and Neurology* and a contributor to many medical and legal journals; in fact his bibliography extends to well over two hundred items. In collaboration with the late Dr. Winifred Richmond, formerly head of the psychological department of St. Elizabeth's, he prepared the textbook, *Handbook of Pyschiatry*, published by Lippincott in 1947.

He was appointed chairman of the committee of Consultants on Occupational Therapy of the Council on Physical Medicine of the American Medical Association in 1945. His work on this committee has always been outstandingly for the benefit of occupational therapy. His advice has been given on the remaking of a film; he has reviewed material which has been submitted for publication; has written an editorial, *An Outline Of The Development And Aims of Occupational Therapy*, which was published in the

Archives of Physical Medicine, March, 1948; and always has upheld all reasonable objectives of this profession. His personal acquaintance with prominent persons in allied professions has made his contributions of inestimable value.

Dr. Overholser served as a Fellow on the Board of Management of the American Occupational Therapy Association during the year 1947. Undoubtedly many of the members of this association are not aware of the time and effort which he has given to our profession. He goes about these things quietly and professionally but gets results. At the American Medical Association meeting in June, 1948 he read a paper on *Physical Medicine And Psychiatry, Some Interrelationships* in which one paragraph was devoted to occupational therapy and its place in the scheme of treatment media.

An exhibit on the occupational and psychotherapeutic approach to the maximum security patients at St. Elizabeth's hospital was shown at the American Psychiatric Association Convention in Montreal, Canada, in May of this year. In June, as a member of the committee of the American Medical Association for the Exhibit Symposium on Physical Medicine and Rehabilitation sponsored by the Baruch Committee on Physical Medicine, he was responsible for an exhibit on *Occupationl Therapy In Psychiatry* which was part of this symposium. The complete symposium received special commendation from the committee on awards. Requests to show this exhibit at two other medical conventions have been received and it is a splendid opportunity to explain occupational therapy to the thousands of doctors and guests who attend these meetings. Dr. Overholser requested copies of the new folder on occupational therapy, *A Career of Service in Occupationl Therapy* and these were distributed at the conventions. St. Elizabeth's Hospital has an occupationl therapy department with a staff of fourteen therapists where a broad treatment program is carried on.

Since coming to Washington Dr. Overholser has taken an active part in the medical interests of the District of Columbia. As a member of the Medical Society of the District of Columbia he has been a member of the Sub-committee on Mental Health. He has served as president of the Pan-American Medical Association of Washington, the Academy of Medicine of Washington, and the Board of Managers of the Washington Institute of Mental Hygiene. He is a member of the Executive Committee, United Community Services and Chairman, Health Section of the organization. He is also a member of the Board of the Travelers Aid Society and the Social Hygiene Society. Since 1935 he has served on the Scientific Administration Committee of the National Committee for Mental Hygiene. From the time of its organization in 1936 he has been on the committee on Research in Dementia Praecox, this being the committee which passes on the disbursement of the Scottish Rite appropriation for research in dementia praecox.

Among his other committee work must be included his membership on the Executive Board of Directors of the American League to Abolish Capital Punishment and president of the board of directors of the committee for the Study of Suicide, Inc. A noteworthy honor was bestowed on Dr. Overholser when he was elected a member of the National Board of Medical Examiners in May, 1948. His appointment set a precedent in recognition of the need for a psychiatrist on the Board of Examiners. He is also a Diplomate of the American Board of Psychiatry and Neurology.

As an official of the American Psychiatric Association he has served in many capacities. While in Massachusetts he was a member of the executive committee for many years. He was chairman of the committee on legal aspects of psychiatry, being one of the founders of the section on forensic psychiatry and for one year the chairman of that section. He was elected secretary of the American Psychiatric Association in 1941 and served in that capacity until 1946 when he was made president-elect. He took office as president in May, 1947 and served one year. He has been appointed to the budget committee of the council of this organization this year.

His devotion to the advancement of the professional groups with which he is associated is balanced by the non-medical activities which consume part of his time. Dr. and Mrs. Overholser have three children, Dorothy (Mrs. D. Richard O'Meara), Jane (Mrs. Charles R. Elliott) and Winfred Jr., and five grandchildren.

As chairman of the United States delegation Dr. Overholser attended the Congress on Mental Health in London, England, in August, 1948. Later he and Mrs. Overholser toured the continent.

He has been active in the laymen's organization of the Unitarian denomination and a member of the Unitarian Service Committee since its organization in 1940. One of the projects of this committee is sending medical missionaries abroad. In May, 1946, he was elected Moderator—the highest post in the American Unitarian Association. He is a member of the Cosmos Club in Washington, a 32nd degree Mason, and a member of Alpha Sigma Phi and Sigma Xi.

Biographical sketches of Dr. Winfred Overholser can be found in Who's Who In America; Who's Important In Medicine; and American Men Of Science. His interests are not only those of an administrator and psychiatrist but he is a scholar and friend. Occupational therapists are fortunate to have so distinguished a person actively interested in their professional problems.

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To All O.T.s:

COLORADO is calling A.O.T.A. . . . Attention all members! Convention site spotted for October, 1950, at world-famous GLENWOOD SPRINGS, COLORADO. Meetings to be held at the Colorado Hotel, nestled high among the Rockies clothed in their autumn splendor.

Bathing in natural warm springs pool, which yearly attracts thousands of visitors, will provide fun and relaxation after the days sessions.

Scouting troop reports nearby Aspen ski-tow to operate for visitors. Other well-known sights include Colorado River and Hanging Lake, which it is said, ossifies objects which touch it.

Come equipped for tours, hiking, riding, swimming, square-dancing and bar-b-ques. Civilized dress required only for visits to mile-high city of Denver. Attention camera fans . . . Scenery abundant.

Flash! . . . Data just received! Colorado Hotel noted for elaborate presidential suite. Has been visited by a majority of U.S. Presidents. Reported that when Teddy Roosevelt "slept there" he shot several mountain lions and bears nearby . . .

Early Indian and Western tradition abundant. Reconnaissance scouts send word, "many surprises in store" . . . Local O.T. Troops on all-out maneuvers for your enjoyment.

Signing off . . .
OPERATIONS POW WOW
Colorado Occupational
Therapy Association

July 19, 1949

American Occupational Therapy Ass'n.
Miss Wilma L. West, Director
33 West 42nd Street
New York 18, New York

My dear Miss West:

The Committee on Medical Rehabilitation of the American Psychiatric Association has formulated the following statements of policy to clarify the relationships between Occupational Therapists, Psychiatrists and Physiatrists. The Committee has also voted that your organization be informed of this statement of policy in the hopes that you can agree with our recommendation and will give the statement of policy such publicity as seems proper to you.

"In the field of psychiatry, the prescription of Occupational Therapy must be made by the attending psychiatrist in relation to the total treatment program. To accomplish between the psychiatrist and the therapist, both in the formulation of the problem under treatment, and in the observation on the progress of therapy. It is often difficult to reduce to a few words, on paper, the dynamic mechanisms and human interactions that are such a major part of psychiatric treatment; therefore, a need exists for such direct channels of communication as are essential among other members of the psychiatric team.

In those hospitals where occupational therapy is a part of the Medical Rehabilitation or Physical Medicine Department, the psychiatrist invites the consultation and assistance of the physiatrist. The best interests of the patient require that there always be free and direct communication between the occupational therapist and the psychiatrist."

Very truly yours,

S/ R. A. Chittick, M.D.
Chairman, Committee on
Medical Rehabilitation
American Psychiatric Ass'n

# Major Problem Seen In Need For Occupational Therapists*

## ONLY 2,100 NOW ARE ENGAGED IN PRACTICE WITH AT LEAST 6,000 MORE REQUIRED

By HOWARD A. RUSK, M.D.

Last spring and this summer, the following appeared in one of the nation's medical journals, "Wanted: Graduate Registered Occupational Therapists for progressive all-inclusive program for patients. Modern home, good food, maintenance optional. Liberal retirement plan and illness policy. Paid vacation and holidays. Write . . ."

In the six months the notice appeared, only two letters were received from persons interested in and qualified for the job. One candidate, however, accepted instead a position as a Second Lieutenant in the Women's Medical Specialist Reserve Corps, and the other, when contacted, reported she had accepted another offer.

This week, when the American Occupational Therapy Association meets in Detroit, two equally serious and related problems faced by this group will be the shortage of qualified personnel and the shortage of students in occupational therapy schools.

Long recognized as an important phase of medical treatment, occupational therapy is the therapeutic use of medically prescribed activities such as woodworking, plastics, metal work, printing and ceramics. It may be prescribed for specific restoration of muscle and joint function, as in the case of fractures, burns, amputations and paralyses; for the development of general physical strength and work tolerance, as in cases of tuberculosis, heart disease and other longterm illnesses; for emotional readjustment and as a diagnostic aid in various mental disorders; and for prevocational exploration in the convalescent stage of all illnesses.

As a result of the expansion of occupational therapy, first in Army and Navy hospitals during the war and more recently in Veterans Administration, Public Health Service and other civilian institutions, it has become impossible to meet the demands for qualified occupational therapists. It is estimated that today 6,000 additional occupational therapists are needed in public and private hospitals and crippled children's services. This estimate is based on actual present needs only, and does not include therapists who are needed to expand present services. For example at a recent meeting of psychiatric hospital administrators, it was reported that 12,000 occupational therapists would be needed if adequate treatment were to be given to all of the nation's mentally ill. An equal number are probably needed for expansion of services for the physically disabled.

Today there are only 2,100 practicing occupational therapists, nearly two-thirds of whom are employed in institutions that receive part or all of their support from public funds. Salaries, in general, range from $2,000 to $4,000 a year.

Although low salaries are a contributing factor, they are not the sole cause of personnel shortages. For example, the Veterans Administration alone has more than 175 vacancies ranging from $2,974 for staff therapists to $5,232 for supervisory positions. With the opening of several thousand new hospital beds in the near future, these shortages will become even greater.

Of the twenty-five schools of occupational therapy accredited by the Council on Medical Education of the American Medical Association, twenty have been established since 1941. The total capacity of these schools is about 2,300, but only 1,700 students are now enrolled. The professional education of an occupational therapist requires a minimum of two years, preceded by two years of college. The two years of theoretical training includes biologic and social sciences, clinical subjects, the theory of occupational therapy and technical instruction in the arts and crafts. Students also complete a minimum of nine months of hospital practice in the fields of orthopedics, psychiatry, pediatrics, tuberculosis and general medicine and surgery.

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*Reprinted from: THE NEW YORK TIMES, SUNDAY, AUGUST 21, 1949.

## RETRENCHMENT IS REFLECTED

The reduction in the number of students enrolled in occupational therapy has resulted from a natural retrenchment following the war when the Government subsidized courses. With this support removed, and no other funds available for scholarships, the greatly increased number of schools have not been able to maintain maximum enrollment despite the great need for therapists and the ready availability of employment.

Persons considering the field of occupational therapy as a career should familiarize themselves with the work of an occupational therapist and the requirements for training through visiting hospitals and seeing occupational therapy in action. In some instances, for example, vocational counsellors have advised individuals to study occupational therapy as a therapeutic measure to improve their own emotional adjustment, without consideration of the heavy demands made upon the physical and emotional stamina of the practitioner.

As a career, occupational therapy offers professional status, an outlet for creative ability and imagination, and the personal satisfactions that come from service.

In view of the increasing prevalence of physical and mental disability resulting from chronic disease and an aging population, it is to be hoped that the occupational therapists meeting in Detroit will be successful in devising methods of attracting more qualified persons to this important profession.

## INTERNATIONAL LUNCHEON

KATHERINE STULL, Major, MSC

*Occupational Therapy in Countries Around The World* was discussed at the International Luncheon held August 24 at the Book-Cadillac Hotel in Detroit in conjunction with the 32nd annual conference of the American Occupational Therapy Association.

"Our concept, that man is greater than his disability, is the concept of most nations," said Miss Bell Greve, director of the Cleveland Rehabilitation Center and Secretary General of the International Society for the Welfare of Cripples.

By uniting, occupational therapists the world over can make possible a better exchange of ideas regarding new developments, it was pointed out by therapists from other countries.

The American Occupational Therapy Association, with headquarters in New York City, is always ready to receive foreign visitors and to assist them in planning their itineraries, Mrs. Winifred Kahmann, president of the American Occupational Therapy Association, stated.

Occupational therapists from outside territorial United States who attended the luncheon meeting included: Misses Barbara Fernie and Mary Campbell, Canada; Mrs. Kamala Vishno Nimbkar, India; Mrs. Sigried Maria Lindquist, Sweden; Mrs. Eleanor Brodsky, Hawaii; Mrs. Ethel Bloom Benor, Israel; three students, Miss Conchita Magdaluyo of the Philippines; Misses Jean Mary Archer and Margaret Fletcher of England.

Consular representatives of Canada, Cuba, France, Italy, Poland, Norway, Argentina, Sweden, Peru, Great Britain, and Panama attended the luncheon. The Hon. James J. Hurley, Consul of Canada, was toastmaster.

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The National Needlecraft Bureau, Inc. has available a wide variety of free needlework leaflets which include sewing, knitting, crocheting, embroidery and tatting designs. The leaflets are available without charge in any quantity for distribution. To obtain leaflets, write to the National Needlecraft Bureau, Inc., 385 Fifth Avenue, New York 16, N.Y. specifying kinds of needlework designs desired and quantity of each patterns.

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The Psychodramatic Insitute is sponsoring the eighth and ninth conferences in training in human relations September 3-5 and November 26, 27. Subjects covered will be psychodrama, sociometry sociodrama, group psychotherapy, and therapeutic films. For further information write to the Psychodramatic Institute, P.O. Box 311, Beacon, New York.

# FfeaturedO.T. DEPARTMENTS

## OCCUPATIONAL THERAPY DEPARTMENT

## VETERAN'S ADMINISTRATION NEUROPSYCHIATRIC HOSPITAL*

## LOS ANGELES, CALIFORNIA

ANNE E. BUVENS, O.T.R.
Chief Occupational Therapist and Staff

*Originality and Creativeness are the keynote in our Creative Program*

In a typical California setting, overlooking distant hills and the picturesque village of Westwood, stands the Veteran's Administration Neuropsychiatric Hospital in West Los Angeles, ideally located for the treatment of the mentally ill. To house its 2100 patients, both men and women, there are twelve modern two-story buildings, so placed that views of the surrounding country can be had from each unit.

The patients are divided according to degrees and types of mental illness and as nearly as possible according to age. The women have a building of their own.

Before beginning a description of the occupational therapy department, a word might be said about the physical medicine and rehabilitation service at the hospital. Physical medicine and rehabilitation service, with a psychiatrist trained in physical medicine as its chief, consists of five sections, physical therapy, corrective therapy, occupational therapy, educational therapy and manual arts therapy. Space does not permit a description of the extensive program that is carried on by each, and of the close correlation that exists between each of these and occupational therapy. Suffice to say that all act as an integral part of the medical team, coordinating their services so as to give maximum benefit to the patient.

Approximately 65% of our patients receive some form of occupational therapy. The occupational therapy staff consists of 12 qualified therapists, 10 aides, eight of whom are men, and a secretary. We have approximately 25 volunteers who assist in the various clinics and there are usually three students in clinical training.

Occupational therapy gives treatments throughout the hospital to all patients for whom it is prescribed. Its activities are carried on in twelve clinics and on three words (medical surgical and tuberculosis). The gardens and grounds furnish a large out-of-doors program.

Wherever possible, the patients are treated in clinics rather than on the ward. These are in many cases located in the buildings in which the patients are housed. The clinics are large, well lighted, and are painted in pastel colors, sunlight yellow, pale green and shell pink, with drapes that harmonize. Flowers, music, and paintings (the work of patients), lend an air of informality and hominess, conducive to giving the patient a feeling of security. Murals, used as socialization projects, adorn the walls of some and each is provided with a radio-victrola, with records selected for their therapeutic value.

Our over-all aim is to re-socialize the patient, to restore in him a feeling of self-confidence, a sense of security. Specific aims, based on dynamic concepts, are carried out as nearly as possible with each individual patient. An attempt is made to evaluate the patient and to evaluate the activity in an effort to carry out

*Sponsored by the VA and published with the permission of the Chief Medical Director, who assumes no responsibility for the opinions expressed or conclusions drawn by the author. Photographs were made in the photography shop of manual arts therapy and were posed by personnel.

*The Many Varied Activities in our Textile Shop are Interesting to our Open-Ward Patients*

the treatment aim or aims as indicated by the psychiatrist on the patient's prescription. These aims might be summed up as follows: relief of guilt feeling; creative accomplishments (narcissistic gratifications); acceptable expression of aggression; learning of new skills; or vocational interests.

The prescription also shows the patient's diagnosis and gives such pertinent information as whether he is physicall disabled, assaultive or suicidal. Clinical records are available at all times to assist the therapist in gaining further knowledge of her patients. Progress notes are kept on each patient and forwarded monthly to the psychiatrist in charge.

The modalities that are used are as follows: art (both fine and applied), ceramics, copper tooling, leathercraft, weaving, woodwork and wood carving, basketry, bookbinding, textiles (stenciling, block printing, dressmaking), and millinery. All clinics are equipped to carry on any or all of these activities, depending on the type of patient being treated, the degree of illness, and the safety precautions that have to be observed. Thus, a variety of therapeutic projects are available and assigned appropriately to each patient so that his activities in the clinic do not become routine and subsequently lack interest and progress for him. Stress is placed on the "attitude" the therapist should have toward the patient receiving treatment.

Special mention might be made of several of our clinics that are more or less specialized, insofar as activities and types of patients are concerned. The first of these is a ceramics shop, set up especially for the treatment of patients on suicidal status.

The reasons for selecting ceramics as the main activity in this clinic is that there are no tools with which the patient can injure himself and because it is so easy to interest patients in this activity which can so easily be adapted to meet his specific emotional needs[2]. There is the throwing of the clay on the potter's wheel for those with feelings of aggression, or because of the "dirty work" involved and the cleaning up necessary, the patient with feelings of guilt can derive satisfaction; and it affords an excellent means for the patient to express himself creatively. No special talent is necessary; a patient can "make a mud pie" or he can create a beautiful bowl. Many of our patients have followed it up afterwards as an avocation or even a vocation.

We have a special art studio which is used mainly for closed-ward patients, however privileged patients are often assigned to this clinic

*Art provides Many Opportunities for Narcissistic Gratification*

because of the special therapeutic benefit derived or because they have been found to have exceptional talent and need to be encouraged to continue their art training, after discharge from the hospital[3].

The psychiatrist frequently makes use of the patient's creations in art & ceramics for diagnostic purposes.

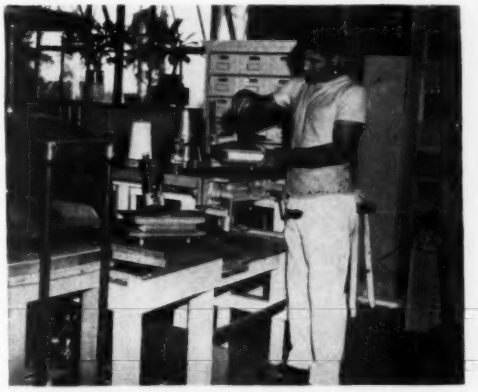
Gardening, carried on as an adult masculine activity, draws patients from many wards. The average number receiving treatment daily is ap-

proximately 100. Many treatment aims can be carried out by means of this activity; hauling dirt in wheelbarrows for the catatonic, heavy shoveling for the man with aggressive tendencies, planting a seed flat, setting out seedlings and watching them grow, affording a patient a means of creative accomplishments. Avocational interests are afforded by learning to make corsages. Brick walls are laid or concrete basins made for lily pools or fish ponds. Patients have assisted in building the lath house and bird houses that have been placed at vantage points in the garden. Construction of a barbecue pit has afforded interest to numbers of patients who were made to feel proud of their accomplishments by a garden party celebration.

The patients on the infirmary ward, largely chronic neurological patients, paraplegics, some of them blind, and many of them in wheel chairs, who were formerly given occupational therapy on the ward are now treated in a clinic set up in the basement of this building. The corrective therapist also works with these patients in a small adjoining clinic. Incidentally, a volunteer, a retired business man, comes to the clinic each week and takes each of the blind patients by turn for a little walk in the sunshine. It is gratifying to see the response that comes from these patients, for the most part in ages ranging from 50 to 80 years of age. Their relatives are allowed on visiting days to come in and visit with them while they work. It is not unusual to hear one of them remark, "This is the brightest spot in Henry's life".

We are in the process of setting up a functional clinic to take care of the neuro-surgical patients. Otherwise, all functional occupational therapy for this type of patient and others, is administered where the patient is assigned.

While the occupational therapy section of physical medicine and rehabilitation largely treats patients from closed wards, it also plays an important part in the treatment of the open-ward or privileged patient. When a patient is transferred to an open ward, he is brought before a staff, composed of the ward psychiatrist and members of the medical team, who make an effort to assign him to the activity that best fits his particular needs. He might be assigned to the woodshop, the textile shop, or the main weaving shop—threading looms. If he is a younger patient, he is usually sent to another section of physical medicine and rehabilitation: the educational, where he can continue his schooling or take up new subjects; or manual arts, where he can learn photography, radio repair, auto mechanics, or woodwork, in an effort to prepare for the time when he must leave the hospital and give some thought to his future vocation. The older patients are usually given an assignment to assist in the library, the dietetic department, the laundry, the grounds, or the clothing room. However, much stress is put on the fact that all these assignments are for therapetuic purposes, to help the patient, and that the productive value is secondary.



*A Hospital Library Book Being Repaired*

In the textile shop, lampshade trimmings woven on small looms, lamp shade making, slippers, drapes, surgical dressings are among the items made there. Most of the patients in this shop are older men. The shop is light and pleasant, with flowers and greenery here and there. Several canary birds, tended by one of the patients, chirp merrily away. And, to add still more to the patient's enjoyment, mid-morning coffee is frequently served.

Therapeutic review boards, presided over by the psychiatrist, are held weekly on each ward. Attending these are the various therapists, the charge nurse, the social worker, the psychologist, and all others who work with the patients on this ward. At these meetings, new patients are staffed, problem patients discussed, and efforts of the various services are thus co-ordinated.

The Veteran's Administration Neuropsychi atric Hospital is used as a training center for residents, social service workers, psychologists,

and occupational therapy students. In charge of this program is the Director of Professional Education, a psychiatrist, assigned to the hospital for this purpose. Many of the lectures, especially those given by leading authorities in the field of psychiatry, are shared by all.

During the fall and winter months, a series of weekly lectures on such subjects as the psychoses, neuroses, psycho-pathology, and neurological disabilities are given to all non-medical personnel in the hospital. These lectures are followed by discussions which are very stimulating to all who attend.

The occupational therapy section has a continuous training program of its own which is being given to all professional therapists who have charge of clinics and who have the immediate supervision of aides, students, and volunteers. This course is conducted by the training section of personnel in cooperation with the chief therapist and consists of conferences and discussions by the various heads. The purpose of this is to enable the therapist to understand hospital problems and the problems of the supervisor, in order that she might thus be helped in solving her own daily administrative problems.

Research work is encouraged on the part of the therapists and aides in order to foster interest in new trends and treatments.

Our student training program is very extensive and covers a period of three months. Students are sent to us from the various occupational therapy schools throughout the country.

Realizing that the hospital is a vital part of the community, every effort is made to establish good public relations. Lectures are given from time to time in the hospital auditorium to patient's relatives in an effort to give them a basic understanding of mental illness and to give them some preparation for the time when the patients will return to them, to take their places in the community.

Exhibits are furnished at all times to organizations requesting them and therapists are always willing to appear before various clubs and to explain to them the meaning of occupational therapy. Our patients recently participated in a nation-wide art exhibit held in near-by Santa Monica.

Hospital day and similar occasions are taken advantage of to publicize the work that is being

(Continued on page 277)

## OCCUPATIONAL THERAPY AT THE CLEVELAND REHABILITATION CENTER

MISS RACHAEL J. MARTINY, O.T.R., Supervisor*

Since 1889 the Cleveland Rehabilitation Center, under various names, has furnished some services for disabled persons in the county. This Center, one of the oldest organizations in Cleveland, started as the Sunbeam Circle which provided recreation for children in a general hospital. In 1919 when interest was being taken in the education, job-training, and development of physically handicapped persons, it became known as the Association for the Crippled and Disabled. In 1938 a new building was constructed to meet the needs of the growing program. In 1943 the name was changed to the Cleveland Rehabilitation Center.

The Center is a private agency and a member of the Cleveland Community Fund, and is under the able direction of Miss Bell Greve. It offers a comprehensive rehabilitation program for any one in the county with a disability (other than hearing or sight), and from whom service has been requested by the physician in charge of the case.

The services now offered are: (1) medical casework and individual planning, (2) physical restoration, which includes physical, occupational, and speech therapy under the supervision of consulting physicians, (3) vocational testing and counselling, and (4) workshops, where training, testing and employment are provided in sewing, woodworking and assembly. A plan is made for each individual patient on the basis of his needs. Frequent conferences and central reporting correlate the services for the benefit of the patient.

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*In collaboration with: Miss Margaret O'Brien, Adult Treatment Shop; Miss Jane Kingsley, Homebound Treatment; Miss Joan Dorfmeier, Cancer Project; Miss Elizabeth Callahan, Children's Therapist; Mrs. Elizabeth Gray, Nursing Home Project.

The Center accepts referrals from doctors of medicine either in private practice or out-patient departments of hospitals. The majority of the referrals are made by private doctors. During a year, 1,300 different individuals of all ages receive service. At one time about 700 different persons are receiving one or more services either at the Center or in their own homes, and 35-50 new applications are received monthly. Station wagons maintained by the Center transport each week 130 to 150 different persons to the Center, some daily and some two or three times a week, according to the individual plan. More than 300 are always receiving physical, occupational and speech therapy, and 120 to 130 are in the vocational and industrial work shops.

The Center has no dormitory facilities and if a patient is referred who needs overnight care, arrangements must be made with licensed nursing homes or boarding homes. Homebound service is available in occupational and physical therapy and homebound industries for those patients who cannot come to the Center.

The total staff at the Cleveland Rehabilitation Center numbers between 55 and 60 and includes, in addition to the five medical consultants, 8 physical therapists, a registered nurse, 6 occupational therapists, 3 part-time speech therapists, 4 social service workers, 7 vocational teachers, a nursery school teacher, a psychologist, a comptroller, 6 office workers, 4 bus drivers, orderlies and maintenance help.

Occupational therapy is a division of the physical restoration department. The staff consists of a supervisor and five staff therapists. The department is at present training students from three schools of occupational therapy and three students are taken for each term. In addition to work under the supervision of each staff therapist, the student has an opportunity to learn how occupational therapists work with other professions, and with other social agencies. Some of these agencies have their offices in the building of the Rehabilitation Center, i.e., Cuyahoga County Chapter of the National Foundation for Infantile Paralysis, which renders services to all persons with poliomyelitis of this county. These consist of casework, and assuming the financial responsibility of medical care including rehabilitation.

Occupational therapy at the Center offers the following kinds of service: home treatment, adult treatment shop, children's division, and special projects. It has long been the policy of the Center to aid in the development of rehabilitation services throughout the community. From time to time therapists from this department have been loaned to other institutions for the purpose of introducing occupational therapy. Some of the departments started in this manner have been: Cuyahoga County Nursing Home, Cleveland Clinic, Contagion Unit of Cleveland City Hospital. Other special projects are described below.

### *ADULT SHOP*

This shop is 21 feet by 105 feet and is partitioned into a store room for the entire department, a woodworking room, and a weaving and printing division, a minor crafts room, and an office. The caseload (58-65 patients per month) is comprised of persons with arthritis, hemiplegia, fractures, tendon transplants, polio, and other orthopedic and neurological conditions. Patients are admitted to this shop for improving co-ordination, increasing range of motion, strengthening, developing work habits and tolerance, and for self-help training. This shop also serves patients with cardiac conditions. It is the policy that all cardiac patients referred to the Center come to occcupational therapy for a period of observation before they are admitted to any other department. During this time their work tolerance is evaluated and they are watched for any undue cardiac symptoms.

In addition to the usual treatment media used, special emphasis is placed on the independence of the patients. They are encouraged to care for themselves as much as possible, and to care for the tools and supplies of the shop, (all tools are mounted in shallow low cupboards so that they can be reached by wheelchair patients). An important step in gaining independence is learning to use public transportation. Following walking training, which is done by the physical therapist the occupational therapist tests the patient on public transportation.

The whole person is the primary consideration of the occupational therapist, thus she works very closely with all other departments serving the patient.

### *CHILD TREATMENT UNIT*

The Cuyahoga County Society for Crippled Children has as one of its projects the Child

*Home Service Therapist and Cardiac Patient*

Treatment Unit of the Center. Physical therapy, speech therapy, nursery school, medical casework, and occupational therapy are offered in this division. About 80% of the children treated are cerebral palsied and the others are congenital deformities, Erb's palsy, fractures and other disabilities. Close co-operation exists between the Society for Crippled Children, the National Foundation for Infantile Paralysis and the Cleveland Rehabilitation Center to insure the best possible treatment facilities for all disabilities.

### *HOMEBOUND SERVICE*

Homebound occupational therapy is available for those patients who are not able to be transported to the Center, and for those who need functional occupational therapy in hospitals where this service is not offered. The average caseload of this therapist is about 35 patients per month. Services to children under this program are sponsored by the Society for Crippled Children. Among those treated are children with rheumatic fever, chorea, severe polio, fractures, burns, arthritis, and other conditions.

The majority of adult homebound patients are in the 25 to 50 age group. About one-third of these are cases for whom early functional treatment is started with the hope that the patient will be able to come to the Center for more intensive treatment as soon as possible.

In another major group are those who because of the severity of their disabilities will probably always remain in their homes or lead very restricted lives. The aim of treatment for these patients is to help them learn how to be responsible for as much of their own daily care as possible, and how to find and develop interests within their physical limitations. The therapist is often called to help a housewife find ways of doing her work from a wheelchair, or to adapt equipment to meet a special need.

The remaining group are those for whom functional treatment by the occupational therapist is not indicated, but who need remunerative employment under restricted conditions. The aim of treatment in these cases is to determine work tolerance and possibilities for work within physical limitations. These cases are then turned over to the homebound industries worker from the Workshops Department. She often consults with the therapist when new projects are to be presented which may require adapting equipment or re-establishing working time.

The homebound therapist is sponsored in part by the Holy Cross House Fund of the Episcopal Church which has a lay committee to help the therapist obtain special equipment. She works closely with other services of the Center who are concerned with the homebound patient, and with community resources for homebound people such as the Library Service for Shut-ins, the Visiting Nurses, and the Board of Education tutors.

The therapist on home service and therapists on special services who make home calls are now in uniform rather than street clothes. The special uniform is dark gray, short sleeved, and worn with a white collar, a blue tie and the insignia on the sleeve. Black shoes, shoulder bag, and bowler hat complete the uniform. The uniform is neat and professional in appearance and makes it easy for the therapist to be identified when treating in homes or hospitals.

### *SPECIAL PROJECTS*

In 1947 funds were obtained from the Cleveland Foundation to be used in a demonstration project in the liscensed nursing homes of the county. These nursing homes are often designated as "commercial" homes to distinguish them from church or public homes;

though privately run they are liscensed by the State Department of Public Welfare. The demonstration is jointly sponsored by the Cleveland Rehabilitation Center, (who assigned a staff therapist), the Division of Aid for the Aged, and the Cleveland Foundation. The purpose of the project was to investigate the need for occupational therapy in these homes, and to find some way in which it could effectively be administered.

There is an advisory committee composed by representatives from community agencies concerned with the aged and the nursing homes. This committee meets to discuss the progress of the project, its problems, and to guide its future development. The committee has been of great assistance to the therapist through encouragement and suggestions.

Five nursing homes are visited weekly by the therapist; and an average of 35 residents are seen during the week. In addition to these homes, four are visited monthly for supervision of the work of volunteers. These volunteers are members of the home's staff who have received 18 hours of training in a special course given by the therapist. Most of the residents are over 60 years of age, and the conditions most frequently found are hemiplegia, blindness, arthritis, cardiac conditions, cancer, and mild mental illnesses.

The project is aimed towards the acceptance of therapeutic activity as an integral part of the services which these homes offer their residents. As this is a new concept to the home operators and residents, it is necessary that considerable time be spent on education in the use of activities for therapeutic reasons.

At present the need for occupational therapy for nursing homes residents is being accepted by the residents, the home operators, and the professional workers who are interested in the homes. We are now working on the problem of the best method of bringing this service to all those who need it.

### *CANCER PROJECT*

In 1949 the Cuyahoga County Chapter of the American Cancer Society and the Cleveland Rehabilitation Center established a demonstration project in occupational therapy. The project was accepted by the department and a therapist assigned one-half time to investigate and demonstrate the need for occupational therapy as a part of the complete medical care of the cancer patient in this community. Plans are being made for this therapist to go wherever the patient is being cared for and the referring doctor feels that the service is needed.

The staff of this department is particularly grateful to Miss Bell Greve for the inspiration and help she has given to further the understanding and development of occupational therapy in this community.

## EDITORIAL

All those who attended the annual convention held at Detroit, Michigan, left with a feeling of accomplishment. The registration was gratifying. Our hats off to the Michigan committee that spent months planning and arranging an outstanding program. We well know the tireless efforts needed by this group to handle the hundreds of details necessary for such a successful event. The 32nd convention of the American Occupational Therapy Convention was outstanding. "Congratulations, Michigan".

We can also congratulate ourselves that among the many fine and loyal people at the convention was one to whom all occupational therapists owe an immeasurable amount—Dr. William R. Dunton, Jr. who added so much to our convention by his attendance. Dr. Dunton, throughout his entire professional career, helped develop and raise the standards of occupational therapy. His counsel and kindly support has always been greatly appreciated and has been a contributing factor to the development of our profession. We thank Dr. Dunton for his efforts and his interest and we gratefully and joyously welcomed him to Detroit.

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Dr. Harry Bauman, Director, Department of Physical Medicine, University of Wisconsin, Madison, Wisconsin, will participate as a visiting faculty member in a continuation course in Occupational and Physical Therapy to be presented October 13 and 14 at the University of Minnesota. The course is intended for occupational and physical therapists. Dr. Bauman will speak on the subjects, "Physical Medicine and Geriatrics" and "Rehabilitation of the Neurological Patient."

# DELEGATES DIVISION

## MASSACHUSETTS

Delegate-Reporter, Elizabeth Collins, O.T.R.

The Massachusetts Association for Occupational Therapy has the following report to submit for the year 1948-1949.

There were four general membership meetings held during the year with an average attendance of from 65-70 members present out of a total membership of approximately 200. The following is a brief discussion of each of the meetings.

(1) A business meeting to discuss the many items which were brought up at the American Occupational Therapy Association's annual convention. The Delegate presented her report and a very active discussion followed. Several members then discussed the papers given at the main sessions of the convention.

(2) With an increasing amount of emphasis being placed on the field of tuberculosis it was felt that one of our meetings should revolve around this topic. A very stimulating program was presented by the staff of the Middlesex County Sanatorium with time being allowed at the end of the formal lectures for a question period.

(3) The Boston Psychopathic Hospital played host for our third meeting with a large number of therapists present. Dr. Robert Hyde discussed the *Role of Occupationl Therapy in a Psychiatric Hospital* which was emphasized very dramatically with a detailed charted analysis. As is the usual practice, Dr. Hyde's lecture was followed by a discussion period and a trip through the occupational therapy department.

(4) The final meeting of the year was an afternoon-evening session held at the U.S. Veteran's Hospital in Bedford, Mass. The afternoon program was devoted to a business session with discussion of the agenda for the House of Delegate's committee reports, and the election of officers. Following this was a tour of the hospital which gave the members the opportunity of observing occupational therapy in a Veteran's Hospital. A very delicious dinner was served by the hospital to the entire membership which was indeed greatly appreciated. During the evening session there were four main speakers with Dr. Sidney Licht presiding.

The Board of the MAOT has continued its policy of holding its meetings on the third Thursday of every month.

Last year the office which we had maintained for many years was disbanded but we found early this year that we needed the services of secretarial assistance. We were fortunate in being able to secure a part time paid clerk who has very satisfactorily solved our needs.

The Public Relations Committee with its sub-divisions has been extremely active this year and we have received a considerable amount of publicity on occupational therapy in general and on our local association meetings in particular.

The American Physical Therapy Association held its annual convention in Boston during June and very graciously invited our association members to their meetings. Many of us accepted. As a small token of our sincere interest in the American Physical Therapy Association our association presented the programs for their banquet. These were cleverly designed by Mrs. Russell Loesch, OTR.

### OFFICERS

President—Miss Lois Sargent, O.T.R.
Vice-Pres.—Mrs. Russell Loesch, O.T.R.
Secretary—Miss Gertrude Shattuck, O.T.R.
Treasurer—Miss Joan Gauchat, O.T.R.
Delegate—Miss Elizabeth Collins, O.T.R.

## TEXAS

Delegate-Reporter, Fanny B. Vanderkooi, O.T.R.

The Texas Occupational Therapy Association held its annual meeting with the Texas Society for Mental Hygiene on March 3rd to 5th inclusive. It received benefit from this full program and then held its own meeting for election of officers at Texas Scottish Rite Hospital for Crippled Children where Miss Cornelia Watson gave a series of demonstrations showing occupational therapy techniques in working with cerebral palsied and convalescent poliomyelitis patients.

Sectional meetings are in the plans of this association and two such meetings have been held in North Texas: One in Dallas and one

in Denton. They have been well attended by the members in that part of the state.

Officers elected were:

President—Mrs. Lucille Land Lacy, O.T.R., Veteran's Hospital, Houston, Texas.
Vice-President—Miss Ann Melcher, O.T.R., Cerebral Palsy Treatment Center, Fort Worth, Tex.
Secretary-Treasurer—Miss Barbara J. Pickett, O.T.R., Veteran's Hospital, Temple, Texas.
Delegate—Mrs. Fanny B. Vanderkooi, O.T.R., Texas State College for Women, Denton, Texas.
Alternate Delegate—Mrs. Susan Mahan, O.T.R.

## DISTRICT OF COLUMBIA

Delegate-Reporter, Violet Corliss, O.T.R.

In an effort to adequately meet the needs of its members the District of Columbia Occupational Therapy Association has had a concentration of efforts directed toward stimulating programs, and group planning for community and national participation.

With an active membership of 44 occupational therapists and 4 associate members the chapter is a progressive one motivated by constructive thinking, planning and acting.

There have been seven regular meetings, and one Tri-State meeting.

In September the meeting was held at the District of Columbia Crippled Children's Society with Miss Corliss, the president, presiding. At this time reports on the many facets of the American Occupational Therapy Convention in New York were given by various designated individuals. The summaries were high-lighted by a report on the meetings of the House of Delegates, and the work and reports of the various committees of the National Association.

A report was made by Miss Messick, chairman of the Publicity Committee, concerning the fact that pamphlets published by the Woman's Medical Specialist Corps were distributed at the convention of 4-H Clubs sponsored by the Department of Agriculture. This proved an effective method of making available pertinent information about occupational therapy to prospective high school students.

The idea of the importance of occupational therapists assuming the responsibility for contacting students in high schools and colleges became a definite challenge and offered a basis for more definite thinking and planning.

The December meeting was a dinner meeting ing held at the Hotel Burlington. Mr. Robin Bon of the Institute of Contemporary Art spoke on *Art Work with Neurotic Children in England During the War.* His talk was illustrated by many examples of paintings which he interestingly analyzed—explaining the interplay existing between emotional and mental states and creative expressions. The picture portrayed of the school and home for neurotic and problem children, in which he worked was very vivid. The approach and philosophy guiding this project is a very progressive one. Various techniques, problems and approaches to solutions were discussed and the meeting ended with a general question and answer period.

On January 12th, Dr. William Reggio, Chief of the Physical Medicine Division, U.S. Public Health Service, was the guest speaker. Dr. Reggio gave a very informative survey of the history and responsibilities of the U. S. Public Health Service and the growth of its hospitals and medical services. The development of the physical medicine division and the future plans for new hospitals and additional personnel were outlined with special emphasis on occupational therapy, its standards for personnel and programs of treatment.

As a result of the business meeting which followed $50.00 was voted to be contributed to the National Office.

Miss Messick as chairman of the publicity committee presented a project for discussion and consideration of the members. The project consisted of drawing a plan for an occupational therapy shop (including architectural plans, general requirements and equipment) to be made available to all occupational therapists and hospitals as a basis for consideration in setting up an occupational therapy department. A general discussion followed and the agreement was reached that Virginia and Maryland Occupational Therapy Associations be contacted for consideration of making a tri-state endeavor. Further investigation of expense and contacts are being made by the chairman.

The February meeting was held at the District of Columbia Crippled Children's Society.

Mr. Frederick Ave Lallemont, of the D.C. Vocational Rehabilitation Service was guest speaker. His subject was *New Rehabilitation Techniques with the Blind,* and he cited many case histories in order to give concrete evidence

of the effective work being done for these handicapped persons. He emphasized particularly the efforts of the rehabilitation service to place blind persons in suitable occupations and enumerated the most commonly encountered difficulties.

Miss Marion Chase of the staff of St. Elizabeth's Hospital Psychotherapy Section was the guest speaker for the March meeting. Her topic for discussion was *Dance Techniques in the Treatment of the Mentally Ill.* Various types of dancing, such as social dancing, square dancing, group rhythmic exercises and spectator participation, were analyzed according to their applicability to specific mental cases. Recounting actual case histories illustrated the application of successful dance techniques.

The business meeting was devoted to a discussion and voting on the new business listed on the tentative agenda for the mid-winter meeting of the Board of Managers of the AOTA.

The members of the Maryland Occupational Therapy Association were hostesses at a tri-state meeting of the Virginia, Maryland and District of Columbia Associations at Perry Point Veteran's Administration Hospital on April 16th. The program was planned by the Maryland Association and there was an enthusiastic participation in the meeting.

To facilitate activity and to most effectively utilize available membership, several committees function as members of the Executive Board of the District of Columbia Occupational Therapy Association. The Program Committee—making contacts and plans for group meetings; the Professional Education Committee — one of the youngest of our committees — with excellent plans for making a distinctive contribution; the Public Relations and Recruitment Committee—placing emphasis upon giving pertinent facts about the field of occupational therapy to the public; and the Membership, Nominating, and Occupational Therapy Department Unit Plans Committees, all of whom have been and are working well.

OFFICERS

President & Delegate—Violet H. Corliss, O.T.R.
Vice-President & Program Committee Chairman—Elsie Smith, O.T.R.
Secretary—Katherine E. Jackson, O.T.R.
Treasurer—Grace Greenlie, O.T.R.
Alternate Delegate—Roberta Aber, O.T.R.

# EVENTS CALENDAR

April 14-17, 1950

Mid-year meeting of the Board of Management of the American Occupational Therapy Association, French Lick Springs Hotel, French Lick, Indiana.

October 14-16, 1950

House of Delegates, Board of Management, and Committee meetings of American Occupaional Therapy Association, Hotel Colorado, Glenwood Springs, Colorado.

October 17-19, 1950

Convention of American Occupational Therapy Association, Hotel Colorado, Glenwood Springs, Colorado.

October 20-21, 1950

Institute of American Occupational Therapy Association, Hotel Colorado, Glenwood Springs, Colorado.

October 4-12, 1950

International Congress of Psychiatry, Paris, France.

# SPECIAL NOTICES

*CONVENTION NOTES*

Roy Manty, Director of Patient Services, Michigan TB Association, delayed the opening of the panel discussion on TB during the Detroit convention because thick fog prevented landing his plane. Finally he made ready to land by instrument and listened intently for his instructions for he was dangerously low. His prompter said, "listen carefully and repeat after me . . . Father who art in Heaven . . ."

The program was delayed only a few minutes. The above must be true for it was related by the moderator himself.

The colorful sandwiches at the Sunday tea were products of OT ingenuity. Lorraine Schubiner, Detroit Medical Hospital, was the creator of same. She thoroughly enjoys such work, having earned much of her college expenses at Wayne U. by making fancy sandwiches for pay.

* * *

Jane Myers, Glenn Dale TB San, was intent on renewing acquaintance with Janet Paterson, now of Michigan Society for Crippled Children and Adults. Seems that some years have passed since the days when Janet had Clinical training under Jane. She was not quite sure she would know Janet, and certainly she had little help in finding her up to the time she got in line at the registration desk and appealed for help in locating one Janet Paterson. her answer came from Janet herself who had been next in line to her for the past several minutes.

* * *

Helen Willard and Clare Spackman lost an hour of wonderful sleep their first morning in Detroit by arriving at the meeting room according to New England time, not Detroit time. They did it once only.

* * *

The three Detroit newspapers totalled 70 inches of copy on the convention. Four pictures, mention within a commercial ad, a window display featuring OT products, and one radio interview, rounded out the publicity locally. Interesting inquiries have followed, proving that it pays to advertise.

* * *

Detroiters were pleased to find a number of the conventioneers eager to drive around Belle Isle after the Sunday tea. The island really has many attractions besides what is seen in the drive . . . beautiful flower exhibits, children's zoo, band concerts, carrillon.

The Weather Man came through with just what was ordered in the way of weather for the convention. He will receive a note of thanks along with all the others who helped to put the convention over.

* * *

Those pictures of Colorado certainly are enticing. And the attractive calendars are happy reminders that we MUST go to the 1950 convention in Colorado.

Those who arrived at the Book-Cadillac for the very first of the pre-convention meetings were somewhat amazed by the confusion of the new carpeting being laid on the fifth floor. It was equally amazing how quickly the confusion was done away. In the matter of a few hours the job was complete.

* * *

In spite of having to cancel the chartered busses for field trips, many OT's found their own way. Many of those who did their visiting within Detroit area found it possible to include several departments during the afternoon.

* * *

Few believed the advance publicity about a car for all who came to the convention. Doubting Thomases!

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*Continued from page* 270

carried on. Last May 12th such an exhibit, in the form of a country fair, in order to give atmosphere, was shown in the recreational hut, with every section of physical medicine and rehabilitation and special services taking part. Patients were on hand to demonstrate the various activities. The patient orchestra and glee club furnished the entertainment. It proved such a success that plans are being made to continue it as an annual hospital event.

And so occupational therapy takes its place as an important spoke in the wheel of rehabilitation for our mentally ill veterans. With the *total-push* method, such as is being used, is it any wonder that each month finds us sending out more than a hundred patients to resume their normal lives in the community.

BIBLIOGRAPHY

1. Harris, Richard L., M.D., Buvens, Anne E., Chief O.T. and Irwin, Isabel, Staff O.T.: *Ceramics as Occupational Therapy for the Suicidal Patient.* O.T. & Rehab., June, 1949.
2. Pessin, Joseph, M.D., & Friedman, Irwin: *The Value of Art in the Treatment of the Mentally Ill.* O.T. & Rehab., Feb., 1949.

# AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

## 33 West 42nd Street, New York 18

*Executive Director*, Wilma L. West, O.T.R.
*Educational Field Secretary*, Eva M. Otto, O.T.R.

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## SCHOOLS OFFERING COURSES IN OCCUPATIONAL THERAPY

1948-49 School Year

| Name of School | Name and Address of Director | Yearly Tuition | Type of Course | Entrance Requirements | Classes Start | Length of Course | Students M | Students F | Enrollment |
|---|---|---|---|---|---|---|---|---|---|
| Boston School of Occupational Therapy Affiliated with Tufts College—School of Education | Mrs. John A. Greene, President<br>Boston School of Occupational Therapy, 7 Harcourt Street,<br>Boston 16, Massachusetts | $500 advanced course<br>$450 for degree course | a. Advanced Course (Diploma)<br>b. Degree (B.S. from Tufts plus B.S.O.T. diploma) | *College degree or accredited professional training<br>Secondary school diploma or qualified transfer student | Sept.<br>Sept. | Approximately 20 months<br>Approximately 44 months | No<br>No | Yes<br>Yes | 108 |
| †Colorado Agricultural and Mechanical College Division of Home Economics | Asst. Prof. Helen Tobiska, OTR<br>Director of Occupational Therapy<br>Division of Home Economics<br>Colorado Agricultural and Mechanical College<br>Fort Collins, Colorado | $180<br>$230 out-of-state residents | Degree (B.S.) | As for the College | Sept. | 4 ac. yrs. plus 10 mo. clin. tr. | Yes | Yes | 43 |
| Columbia University College of Physicians and Surgeons | Miss Marjorie Fish, OTR, Director<br>Miss Marie Louise Franciscus, OTR, Acting Director of Training<br>Courses in Occupational Therapy<br>Columbia University, College of Physicians and Surgeons,<br>630 West 168th St.,<br>New York 32, New York | $600 | a. Degree (B.S. in O.T.)<br>b. Certificate from Faculty of Medicine | *2 yrs. college<br>*A.B. or B.S. | Sept.<br>Sept. | 27 months<br>17 months | Yes<br>Yes | Yes<br>Yes | 71 |
| †Iowa, State University of College of Liberal Arts and College of Medicine | Miss Marguerite McDonald, OTR<br>Occupational Therapy Supervisor<br>Division of Physical Medicine<br>College of Medicine<br>State University of Iowa<br>Iowa City, Iowa | $130<br>$300 out-of-state residents | a. Degree (B.S. from College of Liberal Arts)<br>b. Certificate from College of Medicine | *Entrance requirements of the university | Sept. Feb.<br>Sept. Feb. | 36 months<br>The above plus 9 mo. clinical training | Yes<br>Yes | Yes<br>Yes | 44 |
| Illinois, University of College of Medicine | Assoc. Prof. Beatrice D. Wade, OTR, Director of O.T. Curriculum<br>Department of Physical Medicine<br>Section of Occupational Therapy<br>University of Illinois<br>1853 West Polk Street<br>Chicago 12, Illinois | $55<br>$101 for out-of-state residents | Degree (B.S. in O.T.) from College of Medicine | Entrance requirements for college<br>Upper 50% of class<br>Special physical examination | Oct. Feb. | 6 college semesters on Urbana campus<br>16 months on Chicago campus and affiliating hospitals | Yes | Yes | 74 |
| Kalamazoo School of Occupational Therapy of Western Michigan College of Education | Assoc. Prof. Marion R. Spear, OTR, Director of Occupational Therapy<br>Kalamazoo School of Occupational Therapy of Western Michigan College of Education<br>Kalamazoo 45, Michigan | $127<br>$202 for out-of-state residents | a. Degree (B.S. with major in O.T. & diploma)<br>b. Diploma only | 30 semester hrs. of college credits<br>As above<br>Degree | Sept. Feb. | Approximately 4 academic years<br>As above. | Yes<br>Yes<br>Yes | Yes<br>Yes<br>Yes | 158 |
| Kansas, University of School of Occupational Therapy | Asst. Prof. Nancie B. Greenman, OTR, Director of Occupational Therapy<br>University of Kansas<br>Lawrence, Kansas | $80<br>$180 out-of-state residents | a. Degree (B.S. in O.T.) | Accredited Kansas High School graduate | Sept. Feb. | 45 months | No | Yes | 92 |

| Name of School | Name and Address of Director | Yearly Tuition | Type of Course | Entrance Requirements | Classes Start | Length of Course | Students M | Students F | Enrollment |
|---|---|---|---|---|---|---|---|---|---|
| Michigan State Normal College | Asst. Prof. Gladys Tmey, OTR<br>Supervising Director of Occupational Therapy<br>Michigan State Normal College<br>Ypsilanti, Michigan | $118<br>$193 out-of-state | Degree (B.S. with major in O.T.) | *Entrance requirements of the college | Feb.<br>June<br>Sept. | 45 months | Yes | Yes | 80 |
| Mills College | Mrs. Elsa H. Hill, M.A., OTR<br>Director of Occupational Therapy<br>Mills College<br>Oakland 13, California | | a. Degree (B.A. with major in O.T. plus certificate) | Entrance requirements of the college | Sept.<br>Feb. | 37 months | No | Yes | |
| | | | b. Certificate | Degree from accredited college | Sept.<br>Feb. | 20-23 months | No | Yes | |
| Milwaukee-Downer College | Prof. Henrietta McNary, OTR<br>Director, Department of Occupational Therapy<br>Milwaukee-Downer College<br>2512 East Hartford Ave.<br>Milwaukee 11, Wisconsin | $350 | a. Degree (B.S. with major in O.T.) | *Graduate of accredited high school | Sept. | 46 months | No | Yes | 117 |
| | | | b. Diploma | *As above plus 1 year college or professional training | Sept. | 28 months | No | Yes | |
| Minnesota University of School of Medicine | Miss Borghild Hansen, OTR<br>Director of Occupational Therapy<br>University of Minnesota<br>Minneapolis, Minnesota | $126<br>$270 out-of-state | Degree (B.S. in O.T.) | *High school graduate plus 2 yrs. in Arts College | Sept. | 39 months | Yes | Yes | 86 |
| Mount Mary College | Sister Mary Arthur, OTR<br>Director of Occupational Therapy<br>Mount Mary College<br>Milwaukee 13, Wisconsin | $200 | a. Degree (B.S.) and Certificate | Accredited high school graduate | Sept. | 45 months | No | Yes | 41 |
| New Hampshire, University of College of Liberal Arts | Asst. Prof. Doris F. Wilkins, OTR<br>Supervisor of Occupational Therapy Curriculum<br>University of New Hampshire<br>Durham, New Hampshire | $160<br>$360 out-of-state residents | a. Degree (B.S. with major in O.T. plus Certificate | *High school graduate | Sept. | 32 months<br>Above plus 9 months | Yes<br>Yes | Yes<br>Yes | 71 |
| New York University School of Education | Miss Frieda J. Behlen, OTR<br>Director of Occupational Therapy Curriculum<br>New York University<br>Washington Square<br>New York 3, New York | | a. Degree (B.S.) and Certificate | *High school graduate | Sept.<br>Feb.<br>June | 42 months | Yes | Yes | |
| | | | b. Certificate | One year college | As above | 32 months | Yes | Yes | |
| | | | c. Graduate (M.A.) OTR with college degree. | | | | | | |

| Name of School | Name and Address of Director | Yearly Tuition | Type of Course | Entrance Requirements | Classes Start | Length of Course | Students M | Students F | Enrollment |
|---|---|---|---|---|---|---|---|---|---|
| Ohio State University College of Education | Prof. Martha E. Jackson, OTR<br>Chairman, O.T. Department<br>Ohio State University<br>Columbus 10, Ohio | $30 per quarter<br>$105 per quarter out-of-state residents | Degree (B.S. in O.T.) | High school graduate | Sept. | 39 months | Yes | Yes | 55 |
| Philadelphia School of Occupational Therapy Affiliated with University of Pennsylvania—School of Education | Miss Helen S. Willard, OTR<br>Director, Philadelphia School of Occupational Therapy<br>419 South 19th St.<br>Philadelphia 46, Pa. | $500 | a. Degree (B.S. from University plus diploma of P.S.O.T.) | *High school graduate | Sept.<br>Feb. | 42 months | No | Yes | 89 |
| | | | b. Diploma | *1 year college | Sept. | 26 months | No | Yes | |
| | | | c. Advanced Standing | *College degree or professional training | Sept. | 18 months | No | Yes | |
| Puget Sound, College of | Miss Edna-Ellen Bell, OTR<br>Director of Occupational Therapy and Rehabilitation<br>College of Puget Sound<br>North 15th and Warner St.<br>Tacoma 6, Washington | $300 | a. Degree (B.A. or B.S. with major in O.T.) | High school graduate | Sept.<br>Jan. | 45 months | Yes | Yes | 43 |
| | | | b. Certificate | Degree from other college or university | Sept.<br>Jan. | 27 months | Yes | Yes | |
| Saint Catherine, College of | Sister Jeanne Marie, OTR<br>Director of Occupational Therapy<br>The College of St. Catherine<br>St. Paul 1, Minnesota | $210 | Degree (B.S.) | *Special | Sept.<br>Jan.<br>March | 36-45 months | No | Yes | 40 |
| San Jose State College | Asst. Prof. Mary Booth, OTR<br>San Jose College<br>San Jose 14, California | $21 | a. Degree (B.A.) | High school graduate | Oct.<br>Jan.<br>April | 45 months | Yes | Yes | 117 |
| | | | b. Certificate | College degree | As above | 18 months Minimum | Yes | Yes | |
| Southern California, University of College of Letter, Arts and Sciences | Prof. Margaret S. Rood, OTR<br>Head, Department of Occupational Therapy<br>University of Southern California<br>Box 274, Los Angeles 7, California | $516 | a. Degree (B.S.) plus certificate | *High school graduate (upper ½ of class) | Sept.<br>Feb.<br>July | 45 months | Yes | Yes | 81 |
| | | | b. Advanced Standing (Certificate) | College degree | As above | 18 months | Yes | Yes | |
| | | | c. Graduate (M.A.) | OTR or eligible for OTR with college degree | Sept. | 9 months | Yes | Yes | |
| Texas State College for Women Department of Art | Assoc. Prof. Fanny Vanderkooi, OTR, Supervisor of O.T. Course<br>Texas State College for Women<br>Denton, Texas | | a. Degree (B.S. or B.A. with major in O.T.) | High school graduate | Sept.<br>Feb. | 45 months | No<br>No | Yes<br>Yes | 46 |

| Name of School | Name and Address of Director | Yearly Tuition | Type of Course | Entrance Requirements | Classes Start | Length of Course | Students M | Students F | Enrollment |
|---|---|---|---|---|---|---|---|---|---|
| Toronto, University of Department of University Extension | W. J. Dunlop, B.A., B.Paed., LL.D., Dir. University Extension Course in Occupational Therapy University of Toronto Toronto, Canada | | Diploma | Senior Matriculation | Sept. | 32 months | No | Yes | |
| Washington University School of Medicine | Professor Sue P. Hurt, OTR Dir., Dept. Occupational Therapy Washington University School of Medicine 4567 Scott Ave., St. Louis 10, Mo. | $400 | Degree (B.S. in O.T.) | Two years of college totalling 60 sem. hrs., 36 of which are in required subjects. | Sept. | 27 months | Yes | Yes | 35 |
| Wayne University College of Liberal Arts and College of Education | Asst. Prof. Barbara Jewett, OTR Director of Occupational Therapy Wayne University Detroit 1, Michigan | $150 | a. Degree (B.S. in O.T.) | High school graduate | Sept. Feb. June | 46 months | Yes | Yes | 45 |
| | | | b. Post Degree Certificate | *College degree | As above | 19 months | Yes | Yes | |
| William and Mary, College of Richmond Professional Institute | Miss Elizabeth Messick, O.T.R., Dir. O.T. Training Course Richmond Professional Institute of The College of William and Mary 901 W. Franklin St., Richmond 20, Va. | $200 $300 out-of-state residents | a. Degree (B.S. in Psychology) | High school graduate | Sept. | 45 months | Yes | Yes | 44 |
| | | | b. Certificate | 1 year college | Sept. | 27 months | Yes | Yes | |
| | | | c. Ad. Standing | College degree | Sept. | 19 months | Yes | Yes | |
| Wisconsin, University of School of Medicine | Asst. Prof. Caroline G. Thompson, OTR Director of O.T. University of Wisconsin 1300 University Ave., Madison 6, Wis. | $120 $320 out-of-state residents | Degree (B.S. in O.T.) from School of Education plus certificate from School of Medicine | As for university | Sept. Feb. | 33 months | Yes | Yes | 94 |

*Schools having additional requirements.

# Book Reviews

## THE THEORY OF PLAY

Elmer D. Mitchell, Ph.D., of the Univ. of Michigan
Bernard S. Mason, Ph.D.
A. S. Barnes and Co., New York, 1949

*Reviewed by* Wanda Misbach Edgerton, O.T.R

This volume was designed, its authors state, for students in education, sociology, social administration, group work, camping, physical education, public health, recreation and community organization. They might well have added students of occupational therapy. For the practising therapist it serves as another window through which to gain a refreshing new view of her job and her patient's needs, socially, psychologically and physically.

In four parts the book devotes its first to the *Historical Background of Play* and its last to the *Administration of Play*. In the latter, attention is directed chiefly to public play areas, clubs, camps, and school athletics with a thoughtful chapter on the Play Leader.

It is in the middle sections, *Theory of Play* and *Need for Play* that the therapist will find material more closely related to her needs and problems. The chapter entitled the *Theoretical Explanation of Play* with its exposition of play and the six general types of human desires, (for new experiences, for security, for response, for recognition, for participation and for the aesthetic) offers some sound, meaty thought for the therapist concerned about promoting good hospital adjustment through long hopitalization. Here, too, are principles that offer guidance in directing patient's interests toward hobbies that can serve therapeutically as stabilizing, satisfying activities after he has gone from the hospital.

The need for play in modern life and its relationship to physical and mental growth and health are developed in succeeding chapters. Each chapter has a summary and a selected list of references.

Let no one be misled into thinking that a book concerned with play is only for those who work with children. This is a volume for anyone who works with, or seeks to understand, people. It is recommended certainly for students and even more definitely as a mental pick-me-up for any therapist who has begun to look at her job with jaded eye.

## *LEISURE AND RECREATION*

A Study of Leisure and Recreation in their Sociological Aspects. Martin H. Neumeyer and Esther S. Neumeyer; A. S. Barnes and Co., N. Y.; 1949; 411 pp. Revised Edition.

*Reviewed by* Wanda Misbach Edgerton, O.T.R.

In this revision of an earlier work the authors state that they have planned to deal more with the group aspects of leisure and recreation and less with the theories of play and recreation. They point out, however, that they have not lost sight of the individual in this emphasis of the group, for they recognize that the person and the group are not "separable phenomena".

The book is likely to find a limited reader group in occupational therapy ranks, because it deals with so large a field that only an occasional paragraph or reference can apply to the special problems of the physically or mentally handicapped, or the limitations of the institutions such as hospitals, clinics or special schools.

The work comprises sixteen chapters, each followed by a list of Projects or Exercises suitable for group discussion or class assignment, and a list of Selected References. Chapters most likely to be of interest to occupational therapists are those which trace the historical development of leisure and recreation and give attention to modern trends in other countries of the world than our own. The chapter on Preparing for Leisure offers food for thought on the old question of what occupational therapy may do to make diversional activities during enforced leisure more than mere time passers.

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# Letters to the Editor

Dear Editor:

May I express through your columns my enthusiam for the post graduate course at Warm Springs, Georgia. I have just completed the first three months and hope to return for an additional three months at a later date.

I feel every occupational therapist who is working with physical injuries would find the opportunities afforded here, basic for all their other work. The concepts of treatment of poliomyelitis are clearly presented by Dr. Bennett and his staff and there is ample time for observation of various treatment procedures on patients who present many of the problems associted with this one diagnosis. Each graduate student is assigned a selected group of patients for his or her practices and splendid supervision is given.

Although the occupational therapist practices in her own department, she is given time to observe such other things as muscle testing, walking training, the making of apparatus in the brace shop and functional training. This last has been called *daily activities training* in some centers. A great deal of time has been spent in developing this last as it relates to training the patient in independence. I found it helpful to be able to give some of the tests as well as observe some of the exercises given toward this end.

What one person finds of value may be quite different from another but I gained the most from the opportunities to learn about and give muscle tests. I do not feel after three months that I could give a reliable muscle test but the ramifications of this procedure as applied to occupational therapy are so great that every minute spent on this was valuable. I should add that the patience, time, and skill of the physical therapists who instructed us, particularly Miss Plastridge, was *tops*. They never seemed too busy to answer an OT's questions. One of the major ramifications which muscle testing afforded me might be called *positioning*. Three months was not long enough to work out completely, one's theories on the application of activities for specific exercise and in particular the lighter activities needed by the polio patient. The department as it is set up now, offers a fine opportunity for specific study and cooperative analysis along this line.

It is the opinion of the writer that more of this is greatly needed in occupational therapy today. The combination of theory and clinical practice make this post graduate course of the greatest value. I not only recommend it but feel that if a waiting list of applicants were to develop tomorrow, it would be none too soon.

(Signed)
Lucy G. Morse, O.T.R.

Dear Mrs. Murphy:

Miss Jones has already written to you in regard to our having filled the vacancies in the O.T. Department here at The Seton Institute.

In the past six months we have been in communication with seven schools, the A.O.T.A. placement and have written to a great number of individuals referred to us by these agencies, —all to no avail. Then we placed the ad in A.J.O.T.! Following this, we had several inquiries, and we are glad to say that our two new therapists were contacted in this way.

We thought you might be interested in learning of the success of the Journal's early efforts in the field of classified advertising!

S/ Mrs. Eleanor Stisser Owen, O.T.R.
Director of O.T.
The Seton Institute
Baltimore, Md.

Editor's Note: It is gratifying to know the new department of the Journal is proving successful.

Dear Mrs. Murphy:

This is just a note to tell you how much I and the other four Amaco representative enjoyed the Detroit convention. It was an excellent one in every respect and if conditions permit, we expect to be with you in Colorado next year.

S/ John F. Gormley
Sales Manager
American Art Clay Co.
Indianapolis, Indiana

Dear Mrs. Murphy:

I am finally getting into the old routine again after the very exciting trip to Detroit. It was an enjoyable trip in every way. I want to thank you for all the arrangements made . . .

S/ Robert J. Golka
Manufacturers of Leather Products
Brockton, Mass.

Dear Mrs. Murphy:

You are to be congratulated on the excellent way you conducted the exhibits . . . I know the majority of the exhibitors were well satisfied . . .

S/ Howard J. Tanner
The Handicrafters
Waupun, Wisconsin

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Occupational Therapists for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food, maintenance optional. Liberal retirement plan and illness policy. Paid vacation and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Conn.

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